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ABSTRACT

A study examined how student, teacher, and practitioner/manager perceptions of the philosophy and practice of nursing changed during the Project 2000 demonstration program, which marked a dramatic revision of the curriculum taught at colleges of nursing across England and Wales. Data were collected from the following: literature review; questionnaires completed by 242 students and 78 (33%) of 240 qualified diploma enrollees from two nursing education centers; unstructured interviews with 10 of these enrollees; and focus group interviews with a total of 15 teachers, 21 practitioners, and 15 nurse managers from the two centers. As the Project 2000 course progressed, the students' perceptions shifted from "sick" to "health" nursing with an emphasis on theory and research as a foundation for practice. Students were gradually socialized into the role of professional nurse and were perceived and assessed increasingly as workers rather than learners. Teachers, managers, and practitioners also credited the Project 2000 curriculum with shifting their perceptions of nursing and nursing education. (Sixty-one tables and 132 references are provided. Included among the 27 appendixes that constitute 30% of this report are the following: course outlines; study-related correspondence; student questionnaires; interview guides; demographic characteristics of the study respondents; topic guides; and tables detailing the survey results.) (MN)

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PROJECT 2000:
PERCEPTIONS OF THE PHILOSOPHY AND PRACTICE OF NURSING

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INTRODUCTION

This study was commissioned by the English National Board for nursing midwifery and health visiting in 1991 at a crucial point in the history of nursing education. Dramatic curriculum reforms had taken place with the implementation of Project 2000 across England and Wales. The demonstration districts implemented Project 2000 in 1989 and the first wave followed shortly after. By 1992, at the start of this project the majority of the colleges of nursing had developed a Project 2000 programme. This dramatic curriculum change coincided with a period of economic recession and major changes in the NHS (D of H 1989b). The emergence of a contract culture and the split between purchasers and providers have had far reaching consequences for nurse education. Colleges of nursing merged and moved into the higher education arena, with implications for nurse teachers and nurse education generally. It would be easy to lose track of any one of these changes, and it was therefore considered essential to chart the progress of Project 2000 which has a pervasive impact on the whole nursing community.

The Project 2000 programme was introduced to address the needs of NHS and the community into the twenty first century. The factors influencing policy change included the demographic changes predicted to occur over the next two decades with a reduction in the number of young people available for recruitment to the health professions. It was perceived that this would be compounded by the increased proportion of elderly people in the population, placing demands for a different kind of health care service. Government policy statements also envisaged a shift towards the community provision of health care and increased emphasis on the prevention of ill health (UKCC 1986). There were high expectations of the Project 2000 programme in terms of producing a practitioner who could flourish as a member of a multi-disciplinary team and who could meet the health care needs of the population into the next century. The new nurses of the future were to be the 'knowledgeable doers' who both give and supervise care. They were to have well developed analytical skills and provide evidence based practice. Holistic care was central to this vision of the nurse of the future who was to be a promoter of health with an awareness of factors affecting health and well being. There was a renewed emphasis on direct patient care and on nursing in the community (UKCC 1986). In this context and with the far reaching changes and implications outlined above, it is clearly essential to chart the impact of this curriculum reform on the philosophy and practice of nursing.

The focus of this project was to explore the perceptions of the philosophy and practice of nursing within the context of the Project 2000 reforms, and to identify any issues arising for consideration in the continuing development of nurse education and training. This report presents chapters on the current literature, research strategy and methods and the study findings. Finally the findings are discussed in the context of the current literature, and the implications for nursing and nurse education are presented.

THE AIMS AND OBJECTIVES OF THE STUDY

The aims and objectives for the project were as follows:

1. To examine how student perceptions of the philosophy and practice of nursing have changed during the Project 2000 course.
2. To examine students' perceptions of their future professional contribution within the wider context of multi-disciplinary care provision.
3. To examine how teachers consider the course may have changed their own and students' perceptions of the philosophy and practice of nursing.
4. To examine practitioners' and managers' perceptions of the Project 2000 qualified nurses as professional practitioners.
5. To explore the contribution that the course has made towards the process of professional socialisation.
6. To identify issues arising from the case studies for consideration in the continuing development of nurse education and training.

Chapter 1:
Literature Review

INTRODUCTION

The aim of this chapter is to review the literature which provides the context and sets the scene for the research described in this report. First a very brief overview is presented of the historical perspective of nursing. This is followed by an account of the background leading to the Project 2000 curriculum reform. Existing research on the Project 2000 programme and the experiences of Project 2000 students is then reviewed. Finally, a review of the literature related to the professional socialisation process is detailed, and the chapter ends with the future vision for nursing.

1. 1. NURSING -THE TRADITIONAL PERSPECTIVE

Nursing, in common with most other occupations, has been and continues to be influenced by political and economic, as well as social and environmental factors. There would appear to be more literature exploring the 'political' context of nursing than 'nursing itself'. This point was made by Abel-Smith (1960) who stated:

> *"No attempt is made to provide a history of nursing techniques or nursing as an activity or skill. Little is said about what it was like at different times to nurse, or to be trained as a nurse, or to receive nursing care. What the nurse was taught or who examined her are all questions which are left unanswered."*

Jolley & Brykczynska (1993) link the evolution of nursing to the advances made in medicine and bacteriology. The introduction of anaesthesia opened the way to advances in surgery, which in turn made many physicians begin to recognise the need for higher standards of care. Hence the introduction of the training establishment by Florence Nightingale, which were not without their problems. The failure to provide adequate teaching and the work overload experienced by probationers, were just two. However the idea of training was a novel one and viewed with a degree of hostility by some members of the medical profession, who felt that trained nurses might encroach on, or even challenge their authority.

It would appear that their fears for the time being were misplaced. Nurses were trained to conform and accept, not to criticise or question. As the quote from Miss Mollet, a London matron (1888) illustrates in her article for the Nursing record:

> *" No lesson is harder for a new nurse than that of discipline, the subordination of her will unquestioningly to that of another...never ask 'why', and as seldom as possible 'how'; be content to bear unmerited blame without murmuring...generally, especially if she is at all forward or clever she will be 'put' in her right place."*

Florence Nightingale although far-seeing and forward thinking was also a child of her time, conscious of social class divisions, and her concept of a nurse was that of a member of the servant class. The qualities of a good nurse she envisaged as "restraint, discipline and obedience. She should carry out the orders of the doctors in a suitably humble and deferential way. She should obey to the letter the requirements of the matron and the sister" (Davies 1977).

Palmer (1983) comments, that by the time nursing was organised into a system of training, the image of the nurse as subordinate, servile, domestic, humble, self-sacrificing, and not too learned - was inculcated into society. Such an image was thought to fit well into the Victorian image of the 'ideal woman'. Jolley & Brykczynska (1993) state how nursing was not to break free of its image for many decades. Half a century later a nurse academic was found to write:

> *"Nursing has been secularised, but it has in its bones nearly 2,000 years of submission to religious order. The urge to obey, to kiss the rod, with its obverse love of power, are not absent in a modern world, and nursing, especially institutional nursing, tends to be a refuge, conscious or unconscious, for the naturally submissive."*

By the first decade of the twentieth century nursing as an occupation was emerging as a socially heterogeneous, predominantly female grouping. It was subjected to strict discipline, operating within a hierarchic, bureaucratic framework, poorly remunerated, and experiencing a continued relationship of dominance by and subservience to the medical profession. The dominant influence of the medical profession over nursing and nurse education was set to continue for a further half century; the handmaiden image was to die only very slowly (Jolley & Brykczynska 1993).

The turn of the century, was a period of rapid advance in medical technology and expansion of hospital nursing programmes; there was however not an equivalent advance in nursing competence. Most legal definitions of the period implied that the nurse operated under the supervision of a physician. Nurses failed to identify the aspects of their work that were independent or self directed. However Dock & Stewart (1920) attempt to illustrate the differential development between nursing and medicine. World war two heralded a period of discontent within nursing. The development of recognised, certified or registered grades of nursing compounded the difficulty of defining its function (Henderson 1966). Actual technical skills pertaining to nursing were both increasing in diversity and altering in method of application. Lamond (1974) stated that until the need for specialisation was accepted it remained a one sided struggle for each individual nurse to maintain standards of competence in the total nursing field.

Medical Dominance - 'Helping The Sick'

Hall (1980) describes nursing in the 1970's as firmly centred in the hospital. Nursing students from day one began to practice 'nursing' with the majority of classes taught by physicians. It was not surprising then, that many nurses had no clear concept of what nursing was or should be. Fifty per cent of all schools of nursing in Europe had a physician as its principal. The curricula were heavily weighted in its focus upon medicine, and the majority of courses were at post basic levels, and were offered in medical subjects such as anaesthesiology and radiography. Physicians were seen to control not only themselves but also other health professionals (Hall 1980).

The institutionalisation of almost all care of the ill or injured reduced home nursing, previously provided by nursing personnel, to a bare minimum. Davis (1969) found that the public tended to connect the role of the nurse almost exclusively with the hospital. Hall (1980) stated how the nurse, who should have been the major provider of organised comprehensive nursing services, had come to be thought of as a hospital based worker, concerned mainly with servicing departments of an institution and creating an atmosphere where physician and patient meet and interact. It was stated that most educational programmes at both basic and post basic levels were pathology orientated. The nurse was seen as the sick nurse with more health orientated nursing having little place in the educational programmes of the day. Henderson (1966) acknowledged that seemingly successful institutional regimens often failed to change the patient's way of living that sent him to hospital in the first place. Too often it placed people in settings where shelter from the elements was almost the only fundamental need that was fully met.

The curriculum of the 1960's, whilst mentioning health promotion, was rarely seen to include theories of nursing, nursing process or therapeutics. Students in the practical field found the bulk of their learning experiences related to the development of procedural or ward management skills rather than to the nursing care of a person as a whole. Gerrish (nee Walker), undertaking a small study in 1986, found the experiences of nurses she interviewed (n=10) were similar to those identified by other researchers (Vaughan 1980, Lathlean et al 1986). Newly qualified staff nurses felt they lacked communication skills and Gerrish developed three conceptual categories to describe the data. 'Fumbling along' graphically illustrates how staff nurses learnt to perform their new role, in the light of what they perceived to be inadequate preparation. 'Taking charge of the ward' considered the staff nurses' approach to three dimensions involved in this role, namely direct patient care, clerical duties and the organisation of nursing. "It appeared that the staff nurses' ability to effectively manage the ward was not only influenced by the lack of adequate preparation.....but also by certain values the staff nurses had acquired while students as to what constitutes an ideal staff nurse" (Gerrish 1986 page 173). In particular, the overwhelming desire to be seen to be doing a fair share of the work. This is compatible with the findings of both Clarke (1978) and Melia (1987). 'Metamorphosis', "described the process of maturation and growth that the staff nurse progressed through during the first six months in her new role" (Gerrish 1986: page 174). The importance of 'fitting in' is again congruent with Melia's work (1987) and formed an important aspect of the category 'metamorphosis'. Henderson (1966), in her own training in a general hospital states how technical competence, speed of performance, and a "professional" (actually an impersonal) manner was stressed. Nursing was a series of almost unrelated procedures, with an authoritarian type of medicine practised. Physicians who lectured to nurses simply compressed and simplified the didactic instruction they gave medical students. Not even lip service was given to 'patient-centred care', 'family health service', 'comprehensive care' or 'rehabilitation'. There was a regimented regime of patient care and a concept of nursing as merely ancillary to medicine. With only the rare exceptional thinkers who negated this mechanistic approach. One such thinker appears to have been Taylor (1934 - cited in Henderson, 1966) who accepted the definition of nursing as "adapting prescribed therapy and preventive treatment to the specific physical and psychic needs of the individual," whilst acknowledging that the:

> *"real depths of nursing can only be made known through ideals, love, sympathy, knowledge and culture expressed through the practice of artistic procedures and relationship."*

She anticipated some of the current emphasis on patient centred, individualised care and on the importance of a liberal education for nurses.

Valuing The Need For An Interpersonal Perspective

Since the 1960's there has been a growing recognition that nursing in its broadest sense is defined as both an art and a science which involves the whole patient, body, mind and spirit. The concept of nursing's technical skills, although important, gradually came to be considered in themselves as insufficient for quality care. Knowledge based on physical, biological and social sciences became important requirements for the nurse. It was recognised that fewer mistakes were made with increased efficiency when the nurse understood not only how and what to do, but also why a procedure is carried out in a certain way. The human approach was also acknowledged in the nurse's need to observe intelligently, to listen intently and communicate successfully with patients, families and co-workers. The increasing emphasis on the need for the nurse to interact meaningfully with patients, built upon Nightingale's belief that a good nurse needed the capacity of observation and an understanding of what observed appearances imply. However the 'interactive' emphasis of the nurse in the 1960's contrasts with the rather more one sided view held historically:

> *"The very alphabet of a nurse is to be able to interpret every change which comes over a patients' countenance, without causing him the exertion of saying what he feels."* (Florence Nightingale cited in Skretkowicz 1992 p.169)

Lamond (1974), when asking for Registered Nurses' views on their training in 1974, found the individuality of the patient was thought to be an important feature, 'the essence of nursing'. Although the diversity of opinion expressed in their comments was said to highlight the lack of a single, identifiable, spontaneously expressed central core in a definition of nursing. It was seen as difficult to uncover any basic philosophical core in the answers to a single question.

Partridge (1978) believed that nursing historically and in the early 1980's espoused humanistic, holistic, patient orientated approaches to practice. Nurse education concerned itself with the whole patient and their family, offering effective interpersonal skills at the heart of clinical practice, with patient advocacy on the list of nursing functions. However, Partridge felt in the late 1970's that the profession did not always carry such concepts into everyday practice. Most hospitals remained the antithesis of the above qualities.

Hall (1980) saw the nurse as the worker depended upon 24 hours a day, often acting as a substitute for a host of other workers. In such settings the nursing care of the patient often became a second best. Hall believed the nurse had allowed herself to be pushed away from the one to one patient/practitioner relationship on which the development of every effective personal service based discipline depends. Henderson (1966) believed nurses were often tempted, in the interests of the patient to act as a surrogate for the doctors. This she believed was not the nurse's true role. In assuming it, nurses not only practised skills for which they were ill prepared, but robbed themselves of the time needed for the performance of their primary role. She believed when nurses took over the doctor's role they delegated their primary function to inadequately prepared personnel. Lamond (1974) stated that it was because the nurse was the only category of personnel who was constantly available on the ward, that she was then expected to add many new aspects to her role, thus making nursing a dynamic indefinable concept.

Hooper (1978) felt there to be a need to redress the problems that nurses rarely interact with any purpose with patients, that they are inadequately prepared for this aspect of their work, find it difficult to conceptualise their relationships with patients and place such activity low in their priorities. Anderson (1973) found that both patients' and nurses' expectations of the nurse were similar. They agreed that she should be kind, understanding, patient, sympathetic, cheerful and available to the patient. Emotional support was mentioned more than technical care by both patients and nurses. In contrast doctors stressed technical competence, wanting the nurse to be efficient and reliable. Coser (1962) suggested that patients saw the nurse's essential task as one of lending personal reassurance and emotional support. They described the "good nurse" as one who has a kind or personal manner. They seldom saw the nurse in the decision making field, the information giving field or as having a job that involves much professional skill. Manksch and Tagliocozzo (1962) found patients' evaluation of a good nurse focused on the nurse's mode of dealing with patients; they stressed her personality, wanting her to be friendly, warm, kind and benign.

Academic Influence And Credibility

In 1965 the American Nurses Association took the position that all preparatory nursing programmes should be located within institutions of higher education. In 1966 Reinkemyer found the British nurse opposed higher education because she saw nursing as a vocation requiring dedication rather than education. The term 'academic' was taken to mean armchair teaching and the learning of useless abstractions and therefore a contradiction for nursing. The concept that the student nurse should provide service was fully established, and seen to be limiting the degree to which nurse training programmes could become educationally orientated (Feisel 1963). However Florence Nightingale also acknowledged that 'experience' by itself could not always be equated to good practice:

> *"She who perpetuates the blunders of her predecessors is often called an experienced nurse"* (Florence Nightingale cited in Skretkowicz 1992).

It was believed that to make clinical experience truly educational the student must have the opportunity to see, observe and to practice good nursing care (Katz 1969). The need to combine what the students were taught in theory with their experience of practice was also recognised. Hall (1980) advocated that the nurse teachers should be encouraged to return to the practice field of their choice, with the service situation adjusted to enable them to carry caseloads, as the professor of medicine does. This was seen to call for joint appointments between schools and hospitals or community health services. MacGuire (1966) surveyed students both during their induction period, and throughout their training and post qualification follow up. Their self perception as a student nurse was as a student rather than a nurse, with significant role conflict between her position as learner and her hospital employment as a nurse. Wilson and Startup (1991) had similar findings. Most nurses felt that more time should be devoted to the teaching of students.

By the late 1970's Hall (1980) saw the admission of nursing as a discipline into universities and institutes of higher education as an encouraging trend. There was still a lack of understanding however, concerning the need for graduate courses. Nursing she states is the only profession who expects its graduates to be a completely finished product upon completion of the basic education. In 1963 Feisel stated how professional development was recognised as a requirement of any nurse, who should maintain her knowledge and skill at a consistently high level. In service training programmes were seen as essential for quality nursing together with adequate supervision.

It can be seen therefore that the foundation stones for the curriculum reforms evident in Project 2000 were laid in the preceding decades. Nursing was beginning to shake off the dominance of the medical profession and was perceived by nurse theorists at least as both an art and a science. The admission of nursing into the world of academia and a recognition of the need for continuing professional development was perceived by many as an encouraging trend. Indeed a trend which Project 2000 was to perpetuate.

1. 2. BACKGROUND TO PROJECT 2000 IMPLEMENTATION

The Impetus for Change

> *"To meet the needs of the people, health educators, physicians, social workers, nurses and all other categories of health personnel must constantly evaluate their roles and be ready to modify them for the common good and modify the programmes that prepare them for their work."* (Henderson 1978 p.113)

The concept of Project 2000 can not be described as 'revolutionary' since the seeds were sown some 50 years ago when the Horder Report (RCN 1943) proposed that the education for nurses should be separated from the needs of the nursing service and that the student nurse should be recognised as a 'student of nursing' (Dolan 1993). However little was done and a case for change was made once more by the Briggs Committee (1972), who in its exploration of how members of the profession saw themselves, suggested that the image of nursing retained was one of 'the lady with the lamp' or the 'ministering angel'. Bridges (1990) noted that 'on the whole nurses have remained unassertive and submissive despite enormous developments in their own specialist role'. Orr (1990) comments that while the Briggs Committee Report was published in 1972 it still rings true today and she suggests it is perhaps the traditionalism of nursing that is resistant to all major change.

The vision for the nurse of the 1990's and beyond appears to challenge the more negative aspects of the 'traditionalism of nursing'. This project will hopefully shed some light on whether or not perceptions of the nature and discipline of nursing today remain bound within the resistant traditionalism mentioned by Orr (1990).

Policy Change

In 1984 the UKCC set up a project, with the aim of determining:

> *"the education and training required for the professional practice of nursing, midwifery and health visiting in relation to the projected health care needs in the 1990's and beyond and to make recommendations".* (UKCC 1986 p. 3)

In May 1986 the UKCC published its proposals for the reform of nurse education under the title Project 2000 - a New Preparation for Practice. This paper contained analysis of the case for change, and makes clear the UKCC policy is an integrated strategy, involving educational and management action (Joint letter). The factors influencing policy change included the demographic changes predicted to occur over the next two decades as the number of young people available for recruitment to the health professions will reduce remarkably. This would be compounded by the increased proportion of elderly people in the population, placing demands for a different kind of health care service. Government policy statements also envisaged a shift towards the community provision of health care and increased emphasis on the prevention of ill health. All this would be implemented within a climate of increased emphasis on cost effectiveness and value for money.

By May 1988 the government's acceptance of the need for change was however subject to two conditions related to their concern regarding cost and staffing implications. First, further work had to be done on widening access into nursing. Secondly, concrete proposals had to be developed concerning the role and function of the new support worker, together with the formulation of a suitable framework for support worker training (Elkan & Robinson 1991). One year later the government announced the first wave of 13 demonstration sites and by the summer of 1989, Project 2000 was established. A longitudinal study was funded by the Department of Health to assess the implementation of Project 2000 to provide an opportunity to learn from the experience of 'first round' districts as they took on the task of implementing Project 2000 (Jowett et al 1994).

Project 2000 was stated to represent a full scale reorientation of nurse training, based in institutions of further or higher education, with 'nursing students' supernumerary to service requirements, and their time in clinical settings better supervised and more directly linked to course based learning. Educational placements would take part in both institutional and community settings, with a curriculum more health (as opposed to disease) related and with a new emphasis on people as members of a wider society (Joint Letter).

Curriculum Change

The Project 2000 curriculum represents a major innovation in nurse education and comprises a Common Foundation Programme and a Branch Programme both of eighteen months duration. The former is designed to equip the student with the knowledge and skill base to proceed to the latter (O'Neill et al 1993).

The Common Foundation Programme is college-based whilst facilitating the integration of theory and practice by incorporating a series of short placements to enhance the opportunity to observe and learn from the clinical setting. The Branch Programmes enable the student to specialise in one of four areas, (General nursing, children's nursing and the nursing of people with a mental illness or learning disability). Branch programmes were seen to prepare students to apply broad principles and skills acquired in the common foundation programme to assess, plan implement and evaluate nursing needs of individuals and groups in health and sickness (Joint Letter). Traditionally the emphasis has been on the cure-orientated basis of medicine rather than on developing themes which enhance the concept of care as being central to nursing (Kendrick & Simpson 1992).With a major change in emphasis occurring as students placed the concept of ill-health firmly within the context of normality and well-being, notions of holistic and individualised care replaced the malfunctioning machine concepts inherent within the medical model (Robinson 1991b). The new Project 2000 curriculum was predicted to enhance both the nursing profession's existing qualities and provide the opportunity to use more diverse forms of relevant knowledge (Kendrick & Simpson 1992).

There was also an aim to improve the focus of health care to a range of settings, challenging the notion that nursing takes place primarily in a hospital. The vision was for the students to have 'supervised community placements' - residential care, nurseries, work places, health centres clinics - in order to gain a broad based knowledge of people in health and in sickness, their roles in society and interaction with their environment. (Joint Letter) Only then to move on to hospital settings, observing and practising nursing skills under 'supervision of a qualified nurse'.

Project 2000 educated nurses were projected to have a broader understanding of how society functions, the role each person has within it, the factors which promote health and cause ill health. This understanding was seen to enable nurses to provide holistic care for patients and clients both in the hospital and in the community and help the nurse approach health education and promotion in an appropriate way (Joint Letter).

A major implication for nurse teachers is the move into the health based curriculum, which most would find foreign territory, since their own education would have been rooted within a disease orientated model (Gough et al 1993). The UKCC (1987) emphasised the need for appropriate education and reorientation for teachers and stated that this should be built into Project 2000 implementation plans.

Supernumerary Status

> *"Supernumerary status aims to challenge the perpetuation of a submissive, compliant workforce by attempting to protect the student from the socialising influences of workplace culture"* (Bowman & Thompson 1989).

Historically, basic nurse education has been conducted on apprenticeship lines where students were an essential source of cheap labour. Students' educational requirements were subordinated to service needs. Whilst students were a 'pair of hands', learning took place in a haphazard way, frequently proving difficult for the student to relate clinical experience to classroom learning (Beardshaw & Robinson 1990).

Traditionally the immediate needs of patient care very often took precedence over the learning needs of students. The result was often tension between education staff and service managers. The theory/practice gap of which students frequently complain is linked to this. The Project 2000 collective was able to draw upon research to document the educational deficiencies which arose. It suggested there were also negative consequences on the service side, in the quality of care, fragmentation of care delivery and the time taken up by qualified staff in management and supervision of the student. Supervision of students in clinical areas was often inadequate, forcing them to rely on nursing routines and rituals instead of developing a reasoned and questioning approach to care (Beardshaw & Robinson 1990).

The UKCC (1986) saw grave disadvantages, from an educational standpoint, with students making up 20% of staff delivering the service. It was suggested that, whilst on the wards, learners receive little teaching and little attention to educational objectives. To over come deficiencies and reduce wastage, the UKCC believed learner nurses must be under the control of educationalists and not service managers (Elkan & Robinson 1991) and this would be achieved via the introduction of 'supernumerary status'. The change to supernumerary status was seen as crucial by the Project 2000 collective:

> *"We see [supernumerary status]... as the single most important move in achieving the requisite level of educational control and transforming a situation where at present neither the learner is free to learn nor the teacher to teach."* (Howie 1986).

However the UKCC acknowledged that nursing is a practice based profession and much education must continue to be in the practice setting but educationally determined (UKCC 1987). Project 2000 would mean that student nurses spend, on average, 20% of their time providing a service contribution over three years of training, this compares with an estimated 80% that was spent in service delivery prior to Project 2000. This does not mean that only 20% of the student's time will be spent in a practice setting, since much of student's learning will continue to be practised based (Beardshaw & Robinson 1990). A major source of stress previously experienced by untrained learners should be removed. Project 2000 students should receive proper support during clinical placements and no longer be treated simply as a 'pair of hands' (Howie 1986).

The role of lecturer-practitioner is emerging as a means of resolving the problem of appropriate clinical supervision and where the development of the role is clearly understood, it has been highly successful (Vaughan 1989).

Academic Recognition/ Higher Education Links

The changes made within nurse education and preparation aim to encourage nurses to embrace and build upon a body of knowledge which can inform and improve practice (Orr 1987).

This 'pursuit of intellectualism' has its critics as well as its supporters with some suggesting the increased focus on academia may lead to a paucity of clinical skills (Gough et al 1993). This belief is not however borne out in the case of graduate nurses (Sinclair 1983).

Christman (1988) and Clark (1991) believe the growing affiliation of nursing to the academic domain, the overlap of knowledge and competency with other disciplines - particularly the medical profession- will ultimately create a homogeneity in the preparation of health professionals. Christman (1988) sees such parity with other professionals as central to nurses being able to access and influence decision making at a level that formulates policy and allocates resources. As Gough et al (1993) state this is an important goal of Project 2000 education and one with the most significant impact on clinical practice, the goal of enabling nurses to be proactive, rather than reactive, in the provision of care within the broader socio-economic environment. Nurses are often criticised for their inflexibility and for taking a rule-following attitude rather than developing analytical skills. A new 'building blocks' approach is advocated, concentrating at an early stage on developing problem-solving skills and thinking ability which can be applied to a range of clinical settings (UKCC 1987).

Robinson (1991) states many potential benefits of linking nurse education with higher education have already been identified in one of the Project 2000 demonstration districts, particularly the additional specialised resources and expertise, increased academic credibility and cross fertilisation of ideas. The negative view highlights the potential pitfalls, such as fear of control (Chapman 1990) and the need to retain autonomy (Gruending 1989).

There was general concern that the new education programme for nurses should have unambiguous credibility in general educational terms. Leading to "qualifications which equate with the standard of an advanced educational qualification and which give entry to further courses " (UKCC 1986). It was therefore recommended that joint professional and academic validation should be pursued from the outset to achieve academic recognition for professional qualifications. Project 2000 was therefore to lead to a qualification of 'Registered Nurse Diploma Higher Education'.

Clinical Provision

The UKCC has stated that the practitioner of the future must:

> *"...be competent to assess the need for care, to provide that care, to monitor and to evaluate care and do all this in a range of institutional and non-institutional settings"* (UKCC 1986 p. 40).

This new nurse will work in partnership with patients in designing care plans aimed at fostering independence and autonomy (UKCC 1986). It is in the community that some envisage the greatest impact on practice will occur in the light of the new practitioner being qualified, for the first time, to work in both institutional and non-institutional settings (Gough et al 1993). Nursing, as frequently stated, is a practice based profession and the quality of practice ultimately hinges on appropriate and rewarding clinical placements. The importance of access to relevant clinical areas cannot be overemphasised if diplomates are to gain the necessary skills for improved professional practice, the ultimate aim of Project 2000 (Gough et al 1993). It was perceived that traditional students may initially have greater clinical experience but in turn the Project 2000 student may have a greater awareness of community and social issues. It was hoped that with good will and sensitive management each can share knowledge and skills and benefit from the other. Clinical experience for the Project 2000 student was envisaged to be related to the stage the student had reached in their course with a greater proportion of clinical experience occurring in the community to enable the student to function effectively both in hospital and community settings (Joint Letter). Some believe the challenge will be for Project 2000 students to promote health without losing sight of the fact that a significant amount of nursing care is delivered to people who are ill (Dolan 1993).

Research has highlighted the existence of the 'culture shock' (RCN 1985) experienced by students when exposed to their first clinical experience. In order to prevent this continuing, the first year of training was envisaged to be undertaken in areas offering a high degree of protection. The second year should produce students with greater confidence and practical skills enabling them to make a greater contribution to the practical side of their placements. During their third year, the students would be expected to operate from a more autonomous base, where the central themes will be self learning and a much greater contribution to service giving during each placement (Kendrick & Simpson 1992).

Opposition to Project 2000 highlights the differences between those who see nursing as 'work requiring high calibre training for which critical judgement and questioning approach is essential' and those who view it as essentially a 'practical occupation best learned from on-the-job experience'. The Project 2000 nurses spend considerably more time in the classroom setting, but as some believe:

> *"the deeper the theory, the firmer the foundation for practice, and it is knowing why we do what we do that will enable nurses to make sense of what Schon (1987) describes as the high safe ground of the academic institution when seen from the 'swampy lowland' that is nursing practice".* (Dolan 1993 p. 11).

1.3. PROJECT 2000 RESEARCH STUDIES

Implementation of Project 2000

Although the first Project 2000 cohorts commenced their education in the thirteen demonstration districts just six years ago, there have been a number of studies examining the implementation of Project 2000, the course as a whole and the nurses who have qualified from the new courses (for a full literature review see Elkan & Robinson 1995). The following review of the existing research based Project 2000 literature is to provide the context for the current study. It is evident that whilst other studies have touched on a number of the issues pertinent to this project, none have addressed the fundamental issue of the effect of the new curriculum on the philosophy and practice of nursing with the same breadth and depth as this study.

Three studies were undertaken in the initial phases of the introduction of Project 2000 (Elkan and Robinson 1991, 1993, Robinson 1993 , and Jowett et al 1994). They were fundamentally concerned with the process of implementation but inevitably shed light on the course as a whole and the future direction of nursing. Elkan and Robinson produced two interim reports detailing the introduction of Project 2000 into one district health authority (Elkan and Robinson 1991, Elkan, Hillman and Robinson 1993). Initially interviews were conducted with twenty five personnel including ward sisters, managers, pre-Project 2000 students, HCA's and college of nursing staff. The concerns of those interviewed six months prior to the introduction of Project 2000, included Project 2000 nurses' lack of practical experience and a perception of them as "too academic". The authors place the latter observation in the historical context with an examination of nursing as women's work. The perception that Project 2000 students would lack sufficient exposure to practice preceded any commencement of the course. This appeared to be a widely held view, although some respondents were prepared to challenge it, by suggesting there would be an initial skills deficit only. One respondent had visited Australia where a similar programme of nurse education has been in place for some time. The 'Australian Experience' led the respondent to believe that the Project 2000 diplomates would be far more competent than their 'old-style' counterparts within eighteen months of qualification. This was also supported by the early work of Leonard and Jowett (1990) who found their respondents suggested that the Project 2000 students had better inter-personal skills, were quicker to learn and were more sensitive to patients than their traditional counterparts. Other issues examined by Elkan and Robinson (1991) included the role of support workers, the views of traditionally trained nurses towards Project 2000 and the community orientation of the course. This was challenged by the authors who suggest that problems of under-resourcing, and wide differences between hospital and community made it difficult to produce nurses competent to work in a community setting. Supernumerary status was also explored and found to be misunderstood.

Respondents also anticipated the Project 2000 students to be more questioning but not necessarily to question service or patient care decisions. The second interim report continues this work by examining perceptions of Project 2000 in the first two years of implementation through interviews with nursing personnel. The broader context of Project 2000 is explored through an examination of the student service replacement process, the authors concluding that this has contributed to staffing and skill mix problems in a number of ways. Supernumerary status was felt to be better understood as the course progressed, with the perception of it as 'only observing' largely being abandoned. The report highlights the different aims of service and education staff. The former attaching greater importance to the teaching of practical skills than the latter, who place more emphasis on equipping students with inter-personal skills. Issues of supervision, the theory/practice gap and the adult bias of the CFP were also noted.

Robinson investigated the first year of Project 2000 implementation in one of the demonstration districts (1991), and followed up this study with an examination of the experiences three years on (1993). The issues confronting this particular district had a great deal in common with other districts reported elsewhere (for example Elkan & Robinson 1991, 1993, and Jowett et al 1994). It is important to note that all of the initial studies into the implementation of Project 2000 were qualitative studies with small sample sizes.

Jowett et al (1994) were also concerned with the initial implementation of Project 2000, and examined six of the thirteen demonstration districts, through interviews with students, teachers, practitioners and managers. A series of interim reports were produced throughout the project in an attempt to guide those following the demonstration districts in the implementation of Project 2000. The authors suggest that the force of change was immense and that there was a great deal of pressure on those in both service and education attempting to implement the curriculum. The speed of implementation had adversely affected the quality of the courses and the working environment of many staff and students. Nevertheless the authors suggest that there is cause for optimism from the students, and from the staff whose professional practice had been enhanced by the changes. The students gained a great deal from the course and were eager to utilise their skills. There were many examples of academic growth, and an enthusiasm for further study. The nurse teachers had also gained from the course development and their academic confidence was growing. Difficulties identified involved the introduction of the changes and the massive upheaval the shift to supernumerary status entailed. The unease expressed by practice based staff about the Project 2000 changes had an impact on the climate of innovation. "Some of the difficulties encountered (particularly of students in the practice areas) highlighted the consequences of targeting innovation at the entrants to an occupational group, with only limited input to the existing practitioners" (page 4). This was also predicted by Ryan in 1989, and Leonard and Jowett (1990) suggested that the students would require an adequate support structure to enable them to change existing nursing practice.

Project 2000 Qualified Diplomates

Jowett (1995) explored some of the above issues further with a specific examination of the 'products' of the course, the Project 2000 diplomates themselves. In this small follow up study questionnaires were sent to the sixty six of the sixty eight students that had been interviewed as part of the initial study (Jowett et al 1994). Fifty seven diplomates (86%) completed the questionnaires 20-24 months after the end of the course. Most of the respondents reported high levels of satisfaction in practical competence, and respondents felt that Project 2000 qualifiers were likely to be different from those traditionally trained in their approach and attitude. Job satisfaction came from contact with clients or patients, and the critical comments from colleagues to those who had qualified on Project 2000 persisted. There was considerable commitment to further training and education, although the context in which the respondents' nursing took place was of increasing concern. An increasing number were thinking of leaving nursing. A study commissioned by the Department Of Health is currently being undertaken by Luker and colleagues at the University of Liverpool. It is examining the 'fitness for purpose' of the Project 2000 diplomates. A national evaluation of Project 2000 in Scotland commissioned by the Scottish National Board is currently being undertaken by Nick May and colleagues (May and Domokos 1993). The findings of both these studies are eagerly anticipated (due to complete end of 1995).

Other research teams have examined particular aspects of the Project 2000 programme or its implementation (White et al 1993, Phillips et al 1993, While et al 1995, Luker et al 1994, Crotty 1992, O'Neill et al 1993). The findings of each of these will be briefly discussed to place the current study in the context of previous research.

Support, Supervision and Assessment of Competencies Within the Context of Project 2000

White and colleagues (1993) were commissioned by the English National Board to investigate the relationships between teaching, support, supervision and role modelling for students in clinical areas within the context of Project 2000 courses. This qualitative study gathered interview and observation data from staff and students in three of the thirteen demonstration centres. They found that the roles adopted by practitioners and tutorial staff varied enormously, and were labelled and understood in a range of different ways. Student/practitioner contact was limited, and there was a lack of educational preparation for practitioners which resulted in poor connections between theory and practice. Tutorial staff, overwhelmed by multiple and competing demands, felt ill-prepared, and had little opportunity to visit practice areas. Their role in the assessment of practice was therefore insignificant, and they struggled to find a new role or identity within the context of the new course. Supernumerary status was interpreted in a variety of ways and was not wholly embraced by practitioners especially when staffing levels were low. Demands on everyone involved were perceived to be great: "Everywhere the students looked to the practitioners for help, the practitioners looked to the tutors for help and the tutors looked for someone themselves". The mental health students reported an adult nursing bias in the CFP, suggesting that their course only began a year and a half after it actually started. Models of good practice were found, where practitioners were themselves benefited from supernumerary days. Students thrived when given responsibility under close and careful supervision and debriefing through reflection was universally welcomed. These findings were however based on a small number of first wave case study sites and there is a need therefore to undertake further research in this area now that the Project 2000 programmes are better established.

Phillips and colleagues (1993) investigated the assessment of competencies in nursing and midwifery education and training. Fieldwork in phase one was completed in nine colleges of nursing/midwifery/health studies through a grounded theory approach. This enabled the generation of issues and themes to be pursued in greater depth in the second phase in a smaller number of centres. Only part of this study involved an investigation of the Project 2000 course, nevertheless the main findings of the study are relevant to the assessment process as a whole in all areas. Assessment was found to be most effective where dialogue and critical reflection were structured into the process. The research process was found to be instrumental to the process of learning with the best means of developing and refining professional judgement, including assessments of competence being through research and education. "Nurses and midwives who are both 'knowledgeable doers' and reflective practitioners' are found most often where research-based professional practice is institution wide and all members of the community are engaged in a process of action, reflection, critique and further action". As in the White et al (1993) study, short placements were found to militate against an effective assessment process.

While and colleagues (1995) were commissioned by the English National Board to compare the intended and actual outcomes of three pre-registration nurse education programmes. The RGN programme, the integrated degree programme and the diploma level RN programme (Project 2000). Data collection methods included participant response to two simulations, non-participant observation of practice and semi-structured interviews with respondents in three different centres, representing each of the three different programmes (n= 99 students in total). The authors conclude that the tremendous number of changes in health care and nurse education resulted in some confounding variables which makes interpretation of the findings necessarily cautious. The data sets were in many respects similar, however some differences did emerge. All students recognised and valued the contribution of nurses in practice to their professional development, which the authors suggest makes the implementation of the UKCC's (1990) preceptorship scheme for all newly qualified nurses imperative. The integrated degree programme students demonstrated their skills in the clinical and simulated settings with higher median scores than the students of the other two programmes. The RGN students demonstrated their extensive clinical practice base and were much influenced by this greater clinical exposure. The Project 2000 students identified perceived confidence deficit in the area of nursing skills and suggested continued learning in the practice setting and more clinical placements as potential strategies for overcoming such deficits. Indeed, RGN and Project 2000 students recommended course modification which the authors suggest may improve the experience of students. The data sets within this study were again fairly small, and as the authors themselves note, caution in the interpretation of the findings is required. Further work in this area would be welcomed.

Role of the Nurse Teacher in the Context of Project 2000

Crotty (1992) and colleagues were commissioned by the English National Board to evaluate the preparation of nurse teachers for their role in Project 2000 programmes. The study, a Delphi survey, commenced in 1988, prior to the initial implementation of Project 2000 in the demonstration districts. Seventy per cent of respondents felt that teaching courses and possession of a degree was important as a preparation for current activities. Eighty six per cent suggested that a management qualification was important. Experience was initially perceived as a means of preparation, although as the respondents became more involved in the new programmes they found their previous experience less useful in the new and dynamic situation. Just over half of respondents had a staff development programme within the college (52%), but over three quarters felt this was important by round three. The authors suggested there was an urgent need to review initial preparation of nurse teachers and their continuing education and development. During the course of the study, other factors influenced the role of the nurse teachers which affected teachers perceptions of their role and preparation. These included the need for nurse teachers to become graduates in a specialist subject (UKCC 1986), for them to be academically and clinically credible (D of H 1989b), and the linking of colleges to higher education institutions (ENB 1989a). A follow-up study, a Delphi study and in-depth interviews in 25 colleges with Project 2000 (1989-1991) was undertaken (Crotty 1993a). There were perceived changes in future role activities to reflect these changes within the context of the overall change to pre-registration diploma level education (Project 2000). A greater involvement with students in the clinical area was forecast, with assessment of students remaining a high priority. Recruitment remained a low priority across all Delphi rounds, whilst research activities and management of health care assistants were perceived as new activities for nurse teachers. Further investigation of the clinical role activities of the nurse teachers (Crotty 1993b) revealed a perceived lack of clinical credibility, with none of the 12 participants from the six colleges of nursing undertaking clinical teaching giving care to a patient with a student. The author suggests this is contrary to the anticipated aim of Project 2000, where the nurse teacher was expected to supervise and teach patient care (UKCC 1986).

Luker and colleagues (1994) were also commissioned by the English National Board to examine the role of the nurse teacher. This study commenced in 1991, when Project 2000 had been implemented in the demonstration districts and was therefore an attempt to identify the evolution of the nurse teachers role in the light of educational reform (Project 2000). The study utilised a modified Delphi technique, telephone interviews, and a case study comprising questionnaires, in-depth interviews and documentary review as methods of data collection. The authors conclude that there were different opinions regarding the current and future role of nurse teachers. The majority of the differences were around the clinical role and the academic role of the nurse teacher. There were found to be a high level of concern over the way in which Project 2000 students acquire clinical skills, which was reflected in the emphasis the sample placed on the clinical role of the nurse teacher. The teaching of students in the clinical area did not receive priority within the curriculum. The authors suggest that whilst the theoretical aspects of nursing are important, the balance should be redressed so that theory does not remain the paramount importance for nurse teachers. The authors conclude that "Nursing education must support and facilitate teachers to maintain and update their clinical skills and so redress the balance which currently is heavily weighted to the primacy of the teaching of theory" (page 200).

1. 4. SOCIALISATION INTO THE PROFESSIONAL NURSING ROLE

The process of socialisation into the nursing role is often called professional or occupational socialisation. This is "a complex interactive process by which the content of the professional role (skills, knowledge, behaviour) is learned, and the values, attitudes and goals integral to the profession and sense of occupational identity which are characteristic of a member of that profession are internalised" (Goldenberg and Iwasiw 1993 page 4). There is a wealth of information on this subject, and readers are directed to reviews of the literature elsewhere (Conway 1983, Melia 1987, Goldenberg and Iwasiw 1993).

In North America Kramer's 1974 work on 'reality shock' has been recognised as a seminal work on the process of becoming a qualified nurse. "Reality shock is a term used to describe the phenomenon and the specific shock like reactions of new workers when they find themselves in a work situation for which they have spent several years preparing and for which they thought they were going to be prepared and then suddenly find that they are not" (page viii). Professional ideals give way to bureaucratic allegiance, once nurses are exposed to the employing organisation. "Conflicting loyalties to the professional and bureaucratic systems of work organisation leads to reality shock, a condition that is detrimental to the individual, the profession and to society" (Kramer 1974 page 24). To attempt to overcome this discrepancy Kramer devised a 'Reality Shock Programme'. This programme was designed to help nurses cope with the transition from student to qualified nurse. It was given alongside other education to two classes of students for three years. A 'control group' class did not receive the intervention. This latter group experienced much more 'reality shock' than those who had experienced the programme, who stayed in their initial jobs longer and did less subsequent 'job hopping'. Those who had received the programme, also remained in nursing practice longer. In summary the programme was quite effective; there was less reality shock; those who had received the programme were happier and more content in their jobs; retained their professional beliefs, and managed the school/work conflict better.

The classic UK study of the occupational socialisation in nursing in the United Kingdom is Melia's work (1987), based on student nurses accounts of their experiences of training, and illustrates clearly the tension already discussed above. This tension exists between the theoretical version of nursing and the practical experience on the wards, where pragmatism prevails and the emphasis is on 'getting the work done'. In thinking about the socialisation of the staff nurse and in preparing the student for the work of a qualified nurse, Melia suggests that the students' training could in no way be described as an anticipatory socialisation process. Students, "when faced with questions about how they might deal with a situation when they were staff nurses, tended to take a 'cross that bridge when we come to it' approach" (page 172). She also suggests that the student experience does not prepare the student for working as a qualified nurse, but prepares them for 'fitting in' to any given system of nursing and for 'getting the work done'. For anticipatory socialisation to occur Melia suggests that the students would need to spend longer periods of time in one place and to take more responsibility, so that their work would more closely resemble that of a staff nurse. Melia's study although small scale and a qualitative study gained a great deal of respect in the nursing community as all nurses recognised themselves or colleagues in the data, what Sandelowski (1986) calls "fittingness".

Bradby (1990) and Wilson and Startup (1991) also examined the process of socialisation into nursing through studies of pre-Project 2000 students. Bradby (1990) followed four cohorts of students during their first year of training (1983) in two schools of nursing using multiple research methods. She suggests that occupational role identity occurs between 6 and 10 months after entry into nurse training. The status passage includes anticipation, entry, contrasts and changes which are often accompanied by surprise, and reality shock, before making sense of the passage some months later. The author also suggests that it is necessary for the students to experience a loss of personal identity through divestiture, and that the status transition is easier for those with higher self-esteem and lower anxiety scores.

Wilson and Startup (1991) conducted a comparative study of the professional socialisation process of student nurses of three nurse education centres in South Wales. Three student cohorts were interviewed at the beginning and end of the first year of training. The authors conclude that the students do not undergo a homogenous and integrated professional socialisation process and have to share the conflicting and divergent values of others if they are to become 'good nurses'. Important differences were noted, which included the types of staff and wards encountered by the students. The surgical wards (as opposed to the medical wards) appeared to provide the more effective clinical placement in terms of opportunities for role modelling. The main problem area however was the dichotomy between the school and the ward. Allied to this there was a decline during the first year in students' expectations of care on the ward to be research based. Indeed, contrary to their objectives nurse teachers felt that the delivery of nursing care was based predominantly upon tradition.

More recently the socialisation of Project 2000 students has been examined in a comparative study undertaken in Northern Ireland. O'Neill and colleagues (1993) were commissioned by the Northern Ireland National Board to investigate and compare the experiences and attitudes of student nurses following the Project 2000 and 'traditional' courses. Multiple methods were used including semi-structured interviews, questionnaires and diaries, to compare the experiences of 'traditional' and 'Project 2000' nurses. This study followed students for the initial eighteen months of the course, and therefore did not report beyond the Project 2000 common foundation programme (CFP). Significant differences were reported between the two groups of students notably in the area of socialisation into the professional role. This study appears to suggest that the 'traditional' students are socialised into the role of the nurse more quickly, will reject the college approach once in the clinical setting, and consider 'real' education to take place in the wards. Project 2000 students appear to be socialised more gradually, will cling to interpretations offered by tutors even in the face of uncompromising ward routine, and take the view that the academic/clinical match cannot be perfect and that material which may appear irrelevant will later have clinical applications. The research team are currently undertaking a follow up study which will follow students until completion of their respective courses.

There may be a tension for the Project 2000 diplomates between holding onto the beliefs and values gained from the course, often appearing "different" to colleagues, or compromising their view of nursing in an attempt to 'fit in' and be accepted in the workplace (occupational socialisation). Ryan (1989) has suggested of Project 2000 that "as a strategy for change it gives the greatest responsibility to the weakest and most inexperienced group" (page 15). He has argued convincingly that in many ways Project 2000 has been constructed "back to front". He suggests that "the students have been given the function of educating the clinical areas; rather than the clinical areas being enabled to prepare students for a new model of practice" (page 1). At present he would suggest that it only endows learners with everything they need to fit in with present practice except the capacity to change it. For the full potential of the Project 2000 diplomates to be reached it is necessary to think about creating an environment ready to receive them and ready to utilise their skills to the full (Ryan 1989).

1. 5. CONCLUSION: THE FUTURE VISION FOR NURSING

In 1982, approximately 50% of all sisters / charge nurses and staff nurses were working in settings outside of the hospital (Bosanquet & Gerard 1985). This was viewed as an important trend which nurse education should both reflect and reinforce. The Project 2000 design group therefore urged a reorientation of initial training towards the community and a lessening of the emphasis on high technology hospital care. It was suggested that there was now a need to produce nurses with the confidence to cope with uncertainty and adaptability to the changing world. The nurse of the future will be a completely 'new animal':

> *"A mature and confident practitioner, willing to accept responsibility, able to think analytically and flexibly, able to recognise a need for further preparation and willing to engage in self development."* (UKCC 1986 p. 33).

The UKCC states that Project 2000 heralds fundamental changes in the way nurses are educated but also in the way nurses will practice in the future. The independence, assertiveness and autonomy of the new nurse contrasts to the perceived failings of the insecure, ritual bound, task orientated one of the past and present (Beardshaw & Robinson 1990). The changes mentioned so far challenge fundamental aspects of the traditional view of what nursing is and who nurses are. The compliant, willing caring and dedicated angel who has no career ambitions (Bridges 1990) is replaced by the flexible, adaptable, critically analytic and autonomous practitioner who is well able to relate intelligently and assertively with other health care professionals (Robinson 1991a).

Project 2000 with its emphasis on health promotion and prevention of illness, aims to produce nurses who are competent, thinking, dynamic and receptive to change. This is often summed up as the reflective practitioner or knowledgeable "doer" (O'Neill et 1993).

> *"The practitioner of the future should be both a "doer" and a "knowledgeable doer". S/he should be able to marshall the relevant information to make an assessment of need, to devise a plan of care consequent upon that assessment, to implement, monitor and evaluate it.. That a practitioner must be a thinking person with analytical skills....The practitioner of the future should be someone who gave care and not someone who supervised it.."* (UKCC 1986 p.40)

The Project 2000 course aims to produce nurses who are orientated towards health as well as ill health and who are able to act as promoters of health. The new practitioners are also expected to base their care on evidence based practice, and view the patient holistically. It was anticipated that this flexible practitioner would challenge others and may act as change agents in the practice areas. The concept of lifelong learning with an emphasis on continuing professional education was also seen to be a product of the new curriculum. The study presented in this report is an attempt to examine any shift towards this "knowledgeable doer" and changes that have occurred in how nursing is perceived, following the educational change reflected in the new Project 2000 curriculum.

When discussing historical origins and developments within nursing, it may be prudent to bear in mind the point made by Rafferty (1992) when she points out that much of the early work on the history of nursing was written from the perspective of the nursing leadership. It was taken for granted that the views of these nursing historians were synonymous with those of the rank and file. Such historical accounts she believes, also take an 'internalist' view of history, which is more often than not 'progress orientated'. The former represents the views of the 'insiders', the latter, whilst often having morale boosting effects, can at times have questionable validity. As Rafferty concludes, the ideal in any historical account would be to have a comprehensive understanding of the multiplicity of factors which either inhibit or facilitate change, to enable a full understanding of events. It is hoped that this report will go some way to facilitating a fuller understanding of the complexities of the philosophy and practice of nursing within the context of the Project 2000 reforms.

The literature presented above was utilised by the research team as a framework for addressing the complex research questions outlined in the introduction of this report. More specifically previous research e.g. questions utilised by Wilson & Startup (1991) were incorporated into the questionnaire design, and together with the UKCC documents (1986, 1989) which outlined the aims of the Project 2000 courses, the literature provided topic focused issues to be addressed in the data collection process. For example the development of a health promotion role in nursing emerged as an issue from the literature as well as from the UKCC documentation. Other broad topic areas included research, holism, the role of the nurse in care delivery, reflective practice, nursing role models and the relationship between theory and practice. These were therefore incorporated into the student questionnaires and the interview topic guides (See appendices 8, 13 and 23).

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Chapter 2 :
Research Strategy & Methods

2. 1. OVERALL DESIGN

To date the experiences of Project 2000 students and newly qualified Project 2000 diplomates remain largely unexplored. Similarly, little work has been undertaken on teachers', practitioners' and managers' perceptions of the philosophy and practice of nursing within the context of Project 2000. Case study design utilising primarily qualitative methods was therefore the design of choice. Qualitative research methods seek to enable exploration of new areas of knowledge, and adopt the emic perspective, exploring the issue from the perspective of the informant rather than from the researcher's perspective. Whilst some quantitative methods and systems of analysis have been utilised, primarily with respect to the questionnaire data, the study on the whole has utilised qualitative methods within the naturalistic paradigm (Lincoln & Guba 1985). The focus therefore is on depth and breadth of understanding of the philosophy and practice of nursing at a time of unprecedented change, rather than on statistical inferences, which may fail to explain the interrelationship of phenomenon in complex situations (Finch 1986). Data were generated from two case study centres to facilitate the in depth exploration of the research question.

Selection of Centres

The following criteria were taken into consideration when centres were being considered for inclusion in the study:

1) Centres at the end of first wave, beginning of second wave in their commencement of Project 2000. Centres that had commenced the Project 2000 programme by 1991, so that the first graduates would emerge in 1994 or before. This was important so that access to qualifiers could be gained within the life of the project.

2) Regionally contrasting centres - North / South

3) Centres who did not feel over researched

4) Centres who were willing to participate

5) Centres with at least 2 intakes of students per year

6) Centres which offered at least 3 out of the 4 branch programmes

Four study centres were identified that met all the above criteria and these were informally approached. Three were willing to participate, and from these the two centres with the largest potential cohorts were chosen. One study centre (Centre 1) was in the North of England, and the other (Centre 2) was in the South.

Study Centre Profiles

Centre 1

The Nurse Education Institution which is in the north of England provides nursing and midwifery education for a very large geographical area. The Institution is an amalgamation of three schools of nursing, one midwifery school and one school of radiography. Relations were formalised with a college of higher education in the spring of 1991 with the signing of a mutual agreement of association. The nurse education institution integrated fully with the Higher Education Institution (now a University) in September 1995. The Diploma of Higher Education (Nursing Studies) commenced in January 1990. The college offers three branch programmes on the Diploma of Higher Education (Nursing Studies): Adult, Child and Mental Health. (Since January 1993, learning disabilities has also been on offer, but this was not available for any of the cohorts within this study). There are a total of approximately 120 nursing teachers and approximately 1300 Diploma of Higher Education (Nursing Studies) students currently in the Institute at any one time. There are three intakes of students per year, January, May and September, with each cohort comprising approximately 90 students. See appendix 1 for Centre 1 course outline.

Centre 2

This Nurse Education Institution in the south of England provides nursing and midwifery education for a total of four NHS Trusts, which provide experience for students in both hospital and community settings. In April 1991 the college of nursing and two schools of midwifery amalgamated with the local college of higher education to form the faculty of Health Care and Social Studies. In July 1993 the college of higher education became a University. There are a total of approximately 27 nursing teachers (excluding midwifery) and a total of approximately 400 students currently undertaking the Diploma of Higher Education (Nursing Studies). Students on the course do however have input from teachers outside the discipline of nursing, from schools within the faculty as well as other faculties. The college offers three branch programmes in the Diploma of

Higher Education (Nursing Studies): Adult, Mental Health, and Learning Disabilities. The Diploma of Higher Education (Nursing Studies) commenced in October 1989. There were originally three intakes of students per year, January, May and October, but since March 1992 there have been two intakes per year, March and October, with each cohort comprising approximately 70 or 80 students. See appendix 2 for Centre 2 course outline.

Methods

A combination and range of data collection methods was employed, in an attempt to illuminate a complete set of research issues. These included:

(i) Self-completion questionnaires, with some four point scales, but primarily consisting of open ended questions which asked for the participants comments and reflections upon certain issues.

(ii) Focus group interviews with a low moderator involvement, and a fairly flexible agenda and topic guide.

(iii) In-depth, unstructured or interactive interviews.

(iv) Attendance at meetings, informal discussions and review of course documentation for contextual data.

Reliability And Validity / Trustworthiness

Issues of reliability and validity were addressed throughout the project. Lincoln and Guba (1985) suggest that conventional criteria for establishing 'trustworthiness', such as internal and external validity and reliability are inappropriate to the naturalistic paradigm. The questions underlying the establishment of these criteria are however appropriate, and may be used as a framework for establishing rigour in qualitative work. They propose that truth value, applicability, consistency and neutrality are the issues underlying the conventional criteria. These underlying concepts will be examined in relation to this study.

Truth Value (Internal Validity)

Truth is subject orientated rather than researcher defined, and truth value is achieved and credible when it presents such a faithful description of human experience that those having the experience would immediately recognise it. In an attempt to address internal validity, the written findings chapter of the qualifier interviews was sent to all participants. It was hoped that participants would recognise their own experiences when presented with the experiences of the group as a whole. Encouragingly those who gave written feedback felt that the findings 'rang true'. Included here are excerpts from two of the letters received as a demonstration of this. One staff nurse commented: " It has been an eye-opener to discover that of the twenty you interviewed many had similar feelings and reactions. It became apparent that experiences they had encountered during the initial transition were almost identical to my own". Another commented: "It is very comforting to know that we all shared similar views regarding the transition from student to staff nurse. At the time my fellow peers always looked and seemed so competent and confident and now I see that they were as worried and anxious as myself".

It is also hoped that other readers will recognise the experience when confronted with it, by the descriptions in this study. Presentations of preliminary findings at research conferences have also suggested others recognise the issues raised and the experiences described. The researchers were careful to avoid 'going native', a major threat to truth value. The experiences of the participants were in many ways quite different to those experienced in the past by the researchers, and indeed the passage of time and the different educational preparation helped guard against this.

The content validity of the research instruments (questionnaire, interview schedule and focus group guides) was addressed by exposing these in draft form to relevant experts, and Project 2000 students and diplomates themselves for guidance and comments. Members of the research steering group were most helpful in this respect.

Applicability (External Validity)

Lincoln and Guba (1985) suggest that 'fittingness' be the criterion against which the applicability of qualitative research be evaluated. In this study it is recognised that those who volunteered to participate may have had quite different experiences from those who declined. As such, those who agree may represent a group of people somewhat different from those who decline (Smith 1981). This research has however not set out to describe the perceptions of students, teachers, managers, practitioners and qualifers, in generalisable terms but rather to explore the experience for a group of individuals. The findings will therefore be unique to that group, but may also have value in their 'fittingness'. That is when findings may fit into contexts outside the study situation, and when the audience views the findings as meaningful and applicable in terms of their own experiences.

The 'elite bias' a threat to applicability (Sandelowski 1986) may be a particular problem in qualitative research, as people who act as participants may be the most articulate, accessible or high status members of the group. Access to the whole cohorts of students within the college of nursing guarded against this for the students. However, this may be an issue for qualifier interview sample, who were self selecting, although the whole cohort were given the opportunity to participate. Focus group participants were purposively sampled, and those agreeing to take part may be unrepresentative. However, within the focus group discussions the participants were asked if they felt the views expressed were representative of other colleagues' views, and in general this was perceived to be the case. Indeed in qualitative research representativeness frequently refers to the data, rather than to the participants or settings per se. (Sandelowski 1986). The researcher has attempted to guard against any elite bias by establishing the typicality or atypicality of participants responses. Robson (1993) points out that covert counting provides the basis for many of the statements made in qualitative research, particularly in generalisations about trends or patterns in the data. The researchers were particularly aware that there was a great deal of overlap and congruence in the experiences and issues raised by all participants, and this included a great deal of consistency between study centres. The focus groups were analysed with consensus issues in mind, and the findings presented on this data set are these consensual issues. Where issues were raised by only one participant or where there was dissension this is noted in the text.

Consistency: The Decision Trail (Reliability)

Lincoln and Guba (1985) propose that auditability be the criterion of rigour relating to the consistency of qualitative findings. A study and its findings are auditable when another researcher can clearly follow the decision trail used by the investigator in the study (Sandelowski 1986). It is with this in mind that the researchers have attempted to provide sufficient detail of the decision trail in this chapter. It is anticipated and hoped that another researcher would arrive at the same or comparable conclusions given the researchers data, perspective and situation.

Consistency within the data collection tools was addressed in a number of ways. Inclusion of items in the questionnaire, interview schedule and focus group guides were based on an thorough review of the literature and extensive pilot work. This pilot work included lengthy discussions with groups of Project 2000 students and some individuals to develop the focus and correct wording of the questions within the questionnaires from the 'emic' perspective. Many of the questions in the questionnaire were open ended, or invited comments and the high degree of consistency achieved in the responses between centres suggests reliability of this instrument. Similarly the responses to the issues in the focus group interviews and qualifier interviews were also remarkably consistent between participants (focus group) and between centres.

During data collection and analysis, the issue of inter-rater reliability was addressed. Both researchers were present at all focus groups, and the same researcher acted as the principal moderator throughout. The researchers regularly conferred with respect to the qualifier interviews and listened to each others audio tape recordings of the interviews whilst they were in progress to maximise consistency. The questionnaires were administered in the same way by both researchers, and the there was a high level of agreement between codes in terms of allocating responses to categories. In addition the technique of triangulation is regarded as a major strategy for addressing issues of reliability and validity. it was anticipated that the triangulation of data investigators and methods (see below) would provide an in-built check on the validity and reliability of the data.

Triangulation

This study employed triangulation as an aspect of its design for the purposes of both 'completeness' and 'confirmation' (Jick 1979). The study design incorporates three basic types of triangulation as identified by Denzin (1978):

(i) **Data Triangulation:** the use of multiple sources of data in a study. This study involves the collection of data from Project 2000 students and qualifiers, nurse teachers, nurse managers, and nurse practitioners.

(ii) **Investigator Triangulation:** The use of multiple individuals to collect, analyse and interpret a single data set. Two members of the research team were simultaneously involved in questionnaire design, administration and analysis, together with conducting the focus group interviews and unstructured interviews and the analysis and interpretation of these. Another researcher and several peers were also involved in independently checking the categorisation of the questionnaire responses.

(iii) **Methodological Triangulation:** the use of multiple methods to address the research question, as outlined above.

Reflexivity

It is acknowledged here that "the research process itself must be seen as socially constructing a world or worlds, with the researchers included in rather than outside, the body of their own research" (Steier 1991). With this in mind the research team have endeavoured to be reflexive in their approach or at least to make explicit who they are and where they are coming from which has inevitably been reflected in the whole research process. (See appendix 3 for biographical insights of the research team).

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Fieldwork

Access

Links had already been made informally with the heads of the nurse institutions when considering centres for inclusion in the study. These initial links were then built upon and meetings were set up with the individual appointed by the college heads to liaise with the research team. Access was successfully negotiated in August 1992 in centre 1, and in November 1992 in centre 2. The research team then began to inform individual members of the institution by personal letter (See appendix 4) which was accompanied by a summary of the project (See appendix 5). Access to service colleagues of each case study centre, i.e. hospital and community managers, was initiated through contacts in the college of nursing. Individual senior managers received introductory letters (See appendix 6) together with project summaries. The researchers also attended meetings to present and explain the research to senior managers.

Ethics

The Royal College of Nursing's (1977) guidelines incorporated in "Ethics related to Research in Nursing" were utilised as a framework for addressing the ethical issues associated with undertaking this particular study. Ethical issues centred around two main areas; informed consent and confidentiality.

Informed consent was sought in which the participants were offered full knowledge of the background of the researcher, the purpose, duration and expected benefits of the research, the procedures that the participants would be involved in, any risks that may be incurred, how the study findings would be used and the sponsorship of the research. Participants were given the choice not to participate in the study, and were free to withdraw at any time.

The confidentiality of the data and of participation in the study was a second ethical consideration. Assurances were given to participants that neither the study centre, their specific place of work, nor their individual identities would be known to anyone other than the research team. All participants were given a code to protect their identity and ensure anonymity, and this was utilised on questionnaires, field notes, audio-tape cassettes and transcripts of the interviews for identification purposes. Only the research team had access to the raw data, and the data were kept under lock and key at all times in order to maintain security.

Ethical approval was not required to access staff and students in the Nurse Education Institution in centre 2. In centre 1 the researchers were asked to negotiate access through the 'nursing ethics committee', which was unproblematic. All participants were fully informed as outlined above, and many were also given a verbal presentation of the project by a member of the research team. It was not necessary to receive ethical approval, for access to managers, practitioners, and qualified diplomates, in either study centre. The senior nurses gave initial consent to access, with individual participants consenting thereafter.

2. 2 . DATA GENERATED FROM PROJECT 2000 STUDENTS

Unlike other participants in the study the students themselves had no basis for real comparison with what has gone before. It was however felt to be important that, particularly with respect to aim 1, opportunities were maximised for picking up change during the course. Careful selection of both the cohorts to be included in the study, and the points of access for questionnaire completion, was therefore imperative. The access points were selected with reference to the following requirements:

1) The need to maximise opportunities for picking up individual change, and group changes over time.

2) The need to explore the potential impact of a wider knowledge base of community health which is expected of Project 2000 students. Therefore one access point would be post community experience, i.e. 9 months into Common Foundation Programme.

3) The need to explore the potential impact of the health orientated approach, in the programmes. Therefore one access point was selected to reflect this. i.e. Approx. 18 months into course.

4) The need to explore the impact on the students of nursing ill people in hospital based care i.e. Approx. 27 months into course.

5) The need to explore the potential impact on student perceptions and the process of socialisation of both " supernumerary status" and "rostered service" i.e. approx. 9 months and 27 months into the course respectively.

Data Collection Method

Questionnaires were selected as the method of choice for the student population in the study. It was known that another on-going study was utilising interviews with a smaller sample of 68 students in some of the demonstration centres (Jowett et al 1994). It was decided that the administration of questionnaires would allow access to a much larger data base, important in the light of the dearth of research in the area, and in illuminating a range of issues pertinent to the research question. It was hoped that this large data base would add to, and build upon the existing work in the area (Jowett et al 1994). Administration of the questionnaires to whole cohorts would allow access to a greater number of students and therefore a wider range of views. This in turn would provide access to a potentially greater number of students whose views may change over the course. We adopted a cross sectional design because of time constraints in relation to understanding the effect of Project 2000 on nurses going through that learning process. Cross sectional work is often an acceptable approach in design terms although the element of approximation to true cohorts is recognised.

Sample

Six access points were proposed ; start of course; 9 months into course; 18 months into course; 27 months into course; 36 months into course, and finally 6 months post qualification. These access points were chosen to coincide with significant points on the course e.g. end of Common Foundation Programme, after rostered service etc. These also allowed access to 4 cohorts 3 times each within the case study centres, which was considered to be important when looking for changes in perceptions. (See table 1 below).

It was also deemed important to maximise the opportunities for accessing cohorts that would qualify in the life of the project so that there was more opportunity for getting a good sample of 'Project 2000 Qualifiers'. Therefore two cohorts in each study centre were selected with this in mind. (See table 1 below) As far as possible an even spread across different cohort intake dates was attempted, as it was suggested in centre 2 that the May cohorts were always a 'different breed.' The researchers wanted to try and get different 'types' of people who entered the Project 2000 course and not just the 18 year old female school leavers who it was assumed would make up the bulk of the September / October intakes. The researchers also wanted a spread of every access point at least once over the three year course. Finalised access points and dates of the collection of data at each point are outlined in table 1 below.

Table 1: Finalised access points for students in centre 1 and centre 2

Intake	Start of course A	9 mths into course B	18 mths into course C	27 mths into course D	36 mths into course E	6 mths after end of course F
Jan '91 Cohort 1, Centre 1 *n=90*				May '93	Jan '94	July '94
Cohort 5, Centre 2 *n=37*				May '93	Jan '94	July '94
May '91 Cohort 2, Centre 1 n=90				Aug '93	May '94	Nov '94
Cohort 6, Centre 2 *n=25*				Aug '93	May '94	Nov '94
Sept / Oct 92 Cohort 3, Centre 1 *n=84*		June '93	Mar '94	Nov '94		
Cohort 7, Centre 2 *n=78*		July '93	April '94	Dec '94		
Mar /May '93 Cohort 4, Centre 1 *n=91*	June '93	Feb '94	Nov '94			
Cohort 8, Centre 2 *n=70*	April '93	Dec '93	Sept '94			

The total sample of respondents was potentially 355 for centre 1 and 210 for centre two giving a combined total sample of 565. Of these 282 (79%) individuals in centre 1, and 181 (86%) in centre 2 completed at least one questionnaire. A total of 498 students from a potential sample of 565 completed questionnaires (82%). (See table 7 in chapter 3 for response rates)

Student Sample Characteristics (see also section 3. 1.)

Demographic information was collected from the students at the first point of access (i.e. at questionnaire A B and D). The age range of the students in the sample was 17- 50, and the branch programmes being studied comprised 78% adult, 13% mental health, 1% learning disabilities, and 6% child branch. Educational qualifications and previous work experience of the whole sample varied considerably. 4% of the total sample were already in possession of degree level education, whilst 6% entered the course via the access / DC test route possessing no formal qualifications. The majority were in possession of GCSE (44%). Several students in both study centres had previously undertaken a pre-nursing course or had commenced a 'traditional' training course (6% of the total sample), and many had previous nursing experience from work as auxiliary nurses or health care assistants (37% of the total sample). Others however had no caring related work (36%) or no previous work experience (3%), having come straight from school or returning to college after a number of years raising a family .

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Data Collection Tool

Given the innovative nature of the Project 2000 course it was necessary for the research team to design a purpose built questionnaire for the study. The use of existing research tools and scales identified from a review of the literature was explored at length (for example, Davies and Oleson 1964) but there was overwhelming concern about the validity of these tools in the context of the new Project 2000 curriculum. A questionnaire was therefore developed following a review of the literature, and particular attention was paid to the underlying principles and philosophy of Project 2000, in particular Rule 18a of the competencies (UKCC 1989). Assistance with the development of the questionnaire was received from members of the steering group and some assistance was received from Dr Startup who has undertaken work on socialisation, and in particular changes in student nurses perceptions during training (RGN course) (Wilson & Startup 1991). It was first essential that the new questionnaire was thoroughly tested and piloted.

Pre-Pilot And Pilot Studies Of Student Questionnaire

Pre-pilot work was undertaken from January 1993 - April 1993. Each pre-pilot study re-tested any amendments made and / or was testing the tool on students on different branch programmes, or at different stages on the course.

Pre-pilot studies were undertaken with students in three nurse education institutions, different from the case study centres. These comprised one in the south of England and two in the north of England. In total 68 students completed questionnaires in the pre-pilot centres. Table 49 in Appendix 7 outlines the stages on the course of these students and their branch programmes:

A college in the north of England, was the centre of the pilot study, where final testing of the questionnaire was undertaken. As shown in table 2 eleven questionnaires were administered to students in the pilot study.

Table 2 : Student Questionnaire Pilot Sample

Branch programme	6 Months	24 Months	36 Months	TOTAL
CFP	6			6
Adult		2	2	4
Mental Health		1		1
TOTAL	6	3	2	11

Analysis of Pre-pilot and Pilot Study Data

Pre-pilot and pilot study data were used to guide development of the questionnaire, and to establish whether the questionnaire was actually accessing the underlying issues that would enable the research questions to be answered. The analysis of the pre-pilot data was undertaken by 'eye-balling' and through discussion within the research team and at steering group meetings. The pilot study data were however subjected to more rigorous content analysis, and these data are presented in the interim report (Macleod Clark et al 1994). As a result of the pre-pilot and pilot work five different questionnaires (Questionnaires A to E) were developed to reflect the experiences of the students at the five different access points across the course. Some questions however were consistent through all questionnaires in an attempt to establish changes over time. (See appendix 8 for Questionnaires A-E).

Main Data collection

The research team negotiated access to the students via the teachers in the colleges of health. The researchers were given an opportunity to explain the research in detail to the students, and this was supplemented with written information (see appendix 9). The researchers also negotiated time to see the students in college to facilitate completion of the questionnaires, and for the researcher to pass on any research knowledge and engage in teaching if this was desired by the students. This enabled the questionnaires to be distributed and completed in the presence of the researcher, and ensured a much healthier response rate than postal questionnaires. Students were free to withdraw from the study at any time, and a few did drop out at subsequent collections, whilst new participants also joined the study. (See appendix 10 for a detailed breakdown of questionnaires completed).

Data Analysis

The questionnaires were subjected to rigorous content analysis and broad thematic response categories were generated for each question. A large number of minor categories were necessary because of the innovative nature of the project. Categories were generated from a grouping of respondents answers (see appendix 11 for a detailed example of the categorisation of the data). However, greater grouping of responses would involve introducing a highly subjective manipulation of the data and could produce distortion. The innovative nature of the study meant that we asked for students perceptions rather than offering a menu to which they could respond. For this reason it is probable that more articulate respondents gave more responses and that some others gave none. We sacrificed a small amount of data from respondents who gave large numbers of answers. So for each question almost a 'modal' number of responses was used for each question (Maximum number of categories). The average number of responses to a question varied between one & six .

These data were entered onto the 'Excel' spreadsheet package on the Apple Macintosh, and frequency counts for each category within each question were derived for each of the two study centres. The majority of the data generated were derived from multiple response questions, and these data are therefore presented simply as descriptive statistics. More detailed analysis was however undertaken on the four point scales. Responses to these were compared within data sets and cross tabulated with demographic variables. Where possible chi-square and Mann Whitney statistical tests were performed within the SPSS package. The four point scales were also compared across data sets and Kolmogorov Smirnov and Sign tests were undertaken utilising the Minitab package. (See appendix 12 for details of each of the statistical tests undertaken). These tests were undertaken to determine any statistical significance between study centres, branch programmes, and different access points on the course.

2. 3. DATA GENERATED FROM PROJECT 2000 QUALIFIED DIPLOMATES

A. Questionnaire Data

Qualifier Sample

Two cohorts of students in each case study centre qualified within the life of the project . These diplomates were sent a postal questionnaire (questionnaire F - Appendix 13) at around 5-6 months post-qualification. These participants had been seen by the researchers on two previous occasions in the college of nursing whilst they were students when they had completed questionnaire D & E. A potential sample of 178 existed in centre 1 and 62 in centre 2 by the end of the course. From this sample 52 completed questionnaires were received from centre 1 (67%) and 26 (33%) from centre 2 (28 participants in centre 1 cohort 1 (31%) and 15 for centre 2 cohort 5 (41%) (January 1991). Twenty four in centre 1 cohort 2 (27%) (May 1991 cohort), and 11 in cohort 6 (44%)). This gave a total of 78 completed questionnaires from an overall sample of 240 (33%).

Qualifier Sample Characteristics

Centre One:

The diplomates who returned their completed questionnaires were between the ages of 20-45, and the majority (81%) had undertaken the adult branch programme. Three quarters of respondents were women, and GCSE was the highest level of qualifications attained by nearly half the sample. One quarter possessed A levels and 19% had previously undertaken some further or higher education. Forty three per cent had previous nursing related work experience, and one person had previously undertaken some traditional nurse training.

Centre Two:

Those who returned questionnaires in centre two were between the ages of 20 and 50, and over 90% of them had undertaken the adult branch programme. Only four respondents were male (17%), and the highest level of qualification for the majority (42%) was GCSE. One quarter possessed A levels and 18% had further or higher educational qualifications. One third of the sample (33%) had some nursing related previous experience, and four people (17%) had previously commenced a traditional nurse training.

Data Collection Tool

The questionnaire for qualified diplomates was developed separately, although it contained some questions in common with other questionnaires (A to E), and was piloted separately.

Pre-Piloting And Pilot Studies

Pre-pilot work was undertaken between March and May 1994. The 'F' questionnaire for qualified diplomates was piloted in two centres, one in London, and one in the north of England. The piloting work consisted of three separate rounds with different groups for each with amendments to the questionnaires after each round of pre-piloting. All diplomates had been qualified between 4 and nine months.

Table 3: Qualifier Questionnaire Piloting Sample

Branch programme	Round 1 (Pre-pilot)	Round 2 (Pre-pilot)	Round 3 (Pilot)	TOTAL
Adult	6	4	2	12
Child		3	2	5
Mental Health		3	2	5
TOTAL	6	10	6	22

Qualifiers Questionnaire: Main Study Data Collection

Participants were sent questionnaires in July and November 1994, to coincide with a six month anniversary as qualified nurses. They had all been seen by the researchers on two previous occasions in the college of nursing whilst they were students. It was therefore hoped that they would feel some loyalty to the study and having met the researchers would continue to participate. However the response rates were disappointing, despite follow-up letters, questionnaires and phone calls. Keeping track of up to date addresses proved both difficult and time consuming. Much as the researchers tried some participants inevitably slipped through the net, and this may be reflected to some extent in the poor response rates.

Data Analysis

The questionnaires returned by the qualified diplomates were analysed in the same way as the student questionnaires. The Excel, SPSS, and Minitab packages were utilised and the qualitative data were subjected to content analysis.

B. Unstructured Interviews with Qualified Diplomates

Data Collection Method

It was felt that the diplomates, as products of a Project 2000 course would be able to illuminate hitherto unexplored aspects of the philosophy and practice of nursing with the benefit of hindsight. It was felt to be important to give diplomates the opportunity to tell their own story. The method of data collection considered appropriate for this was the in-depth, unstructured or interactive interview May (1991) which would most effectively elicit individual opinions and experiences of each informant. By adopting a flexible, unstructured approach, it was hoped that the interviewees would feel able to raise and discuss those aspects of their experiences which they felt were most important and relevant for them. These data therefore supplemented the questionnaire data that the diplomates had already completed.

Interview Sample

An extra question was included at the end of questionnaire F inviting participants to volunteer to be interviewed. The sample was therefore drawn from those participants who:

(i) returned their questionnaire
(ii) Were willing to be involved in an interview with the researcher.

It could therefore be said to be a purposive/convenience sample, being drawn from a self-selecting group. Other criteria were also imposed on the sample to reach the ten people that were interviewed in each case study centre:

Criteria for diplomate interview sample selection

1) Five people from each of the two cohorts (January and May 1991) in each centre. This would allow access to diplomates at 6 and 11 months when the interviews were conducted (December 1994/January 1995).

It was considered important that the sample reflected different lengths of time post-qualification, to allow and compensate for any differences in 'transition' as detailed by Kramer (1974). It was also felt to be important that a sufficient 'settling in' period of time had elapsed.

2) If possible access to staff nurses from different branch programmes would enable common and general themes across all branches of nursing to emerge.

3) At least some practitioners to have experienced some type of formalised support/ preceptorship

4) If possible for practitioners to be working full-time in an NHS post. It was felt that those working in part-time or bank nursing and private nursing posts may have had very different post-registration experiences.

5) In order to minimise differences of experience and to facilitate ease of contact it was decided that all the staff nurses should all be working within the four NHS trusts covered by each school of nursing.

Qualifier Interview Sample Characteristics

Centre One:

As discussed previously, the response rate for the postal questionnaires from which the sample was drawn was disappointing. The qualified diplomates in cohort one (January 1991) returned twenty nine questionnaires from the eighty nine sent out (33%). Of those returned, twenty one agreed to be interviewed. Of these five were working outside the area, eight were working part time, and the five that were interviewed were recruited from the remaining eight who met the above criteria. (See appendix 14 for details of those interviewed).

In cohort two, twenty six questionnaires were returned form a total of eighty nine that were distributed (29%). Fourteen diplomates agreed to be interviewed. Of these, two had moved out of the area, two worked part time, and two returned their questionnaires late. Five diplomates were recruited for interview from the eight meeting the above criteria (See appendix 14 for details of those interviewed).

Those interviewed were working in a variety of hospital settings and one diplomate (mental health branch programme) was working in a community post. All diplomates were in their twenties, and seven had studied the adult branch programme, and three the mental health branch. It was not

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possible to recruit a child branch diplomate for interview. There were six women and three men, and half the sample had previously experienced caring / nursing related work. (More detailed demographic information is presented in chapter 4)

Centre Two:

The response rate in centre two, was also disappointing. For cohort five (January 1991) sixteen questionnaires were returned from the thirty-seven that were sent out (41%). Of the fifteen returned eleven were willing to be interviewed. Five of these did not fit the above criteria, as one was about to commence a midwifery degree and would be leaving her post; one was on maternity leave, one was undertaking bank nursing; another worked part-time in a private nursing home and two were employed in practice areas in other districts, not the four trusts outlined above. Of the six remaining one failed to keep the interview appointment, and declined further follow up and the remaining five as detailed in table 52 (appendix 14) were interviewed.

For the other cohort, (May 1991) only twelve of the twenty five questionnaires were returned (44%). Of the eleven returned seven were willing to be interviewed, however one of these had moved out of the area and another was a bank nurse. The remaining five were interviewed, and are detailed in table 52 (appendix 14).

The diplomates interviewed in centre two, were also working in a variety of hospital settings, and none had gone directly into a community post. The age range of these diplomates were more widespread than their counterparts in centre one, with seven interviewees in their twenties, and the remaining three in their thirties and forties. Eight had studied the adult branch programme and two the mental health branch. It was not possible to interview a diplomate who had undertaken the learning disability branch programme. There were eight women and two men, and the majority of the sample had previous nursing / caring experience. Three had previously undertaken part of a traditional nurse training. (More demographic details are presented in chapter 4).

Data Collection Tool

A loose interview structure was developed and formalised in an interview guide. This included issues arising from the analysis of the questionnaire data. That is any issues which were under explored in the questionnaire, or any issues arising, which merited deeper exploration. (See appendix 15 for interview guide). It was a guide only however, and the participants' issues and agenda were followed as far as possible.

Pilot Interview work

Exploratory work was undertaken with Project 2000 completers. This consisted of a number of informal discussions with those who had gone through the course in an attempt to develop an interview framework. Two pilot interviews were undertaken to test the feasibility of the data collection process and to establish the integrity of the framework for the interviews. Two staff nurse who had been qualified 6 months - one year were interviewed. Both participants had undertaken a Project 2000 adult branch course, and one was working in the London area, the other in the North of England. It was extremely helpful to the process of in-depth interviewing, and helped in the refinement of the interview topic guide. Although these interviews was recorded and transcribed they were not used in the analysis within this study.

The Main Study Qualifier Interviews

Those who had indicated on their questionnaires that they would be willing to be involved in an interview were approached by telephone to confirm their willingness to participate. this was then followed up by letter confirming the arrangements made and giving further information (see appendix 16).

The interviews took place over a period of four weeks (December 1994 - January 1995) at a time and place of mutual convenience. All participants chose to be interviewed in their own geographical area, and most in their own homes. This was felt to be beneficial in helping participants to feel more relaxed in their own environment. General areas for discussion were introduced by the researchers once initial rapport had been established, and all interviews were tape recorded with participants permission. The interviews lasted on average one hour, whilst two interviews were each two hours long.

Interview Data Analysis

This section is concerned with describing the steps taken in the organisation and analysis of the data. The analysis was based on the Lincoln and Guba (1985) adaptation of the Glaser and Strauss (1965) constant comparative analysis.

Framework for Analysis

"Within the naturalistic paradigm...data are not viewed as given by nature but as stemming from an interaction between the enquirer and the data sources. Data are so to speak, the *constructions* offered by or in the sources; data analysis leads to a *reconstruction* of those constructions."

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(Lincoln and Guba 1985 page 332). With this in mind the interview data was analysed inductively and as suggested above was based on the 'unitising', 'categorising' and 'filling in patterns' detailed by Lincoln and Guba (1985). The 'unitising' is a system for identifying units of information that serves as the basis for defining categories. Lincoln and Guba (1985) suggest that a unit should have two characteristics: (1) that it should be heuristic and (2) that it is the smallest piece of information that can stand by itself. 'Categorising' is the process of bringing together the units that apparently relate to the same content, to devise rules that describe category properties and to render the category internally consistent. The set of categories will then be examined for possible relationships among categories ('pattern matching') and the categories will be refined accordingly.

Organisation of Data

It was considered to be very important to organise the data such that it was both easily manageable and so that it could be retrieved easily at a later date. Each participants code number was written on the audio tape, on each page of the transcript, and on each unit of information together with the page number of the transcript. The audio-tapes were transcribed verbatim in Microsoft word software package on the Apple Macintosh. The framework described above (Lincoln & Guba 1985) was written when analysis was undertaken manually on a card indexing system. Morse (1991) has a process which was found to be extremely helpful in organising the data for analysis utilising the Lincoln and Guba approach on the Apple Macintosh.

Thematic Extraction

Each transcript was read through at least once whilst listening to the audio tape, before any formal analysis was undertaken. During a subsequent reading of the transcript on the Apple Macintosh, notes were made both in the margin of the text and in the text itself. The transcript was 'unitised', by identifying units of information that could stand by themselves. In fact in this first 'analysis' the units tended to be large chunks of data, that had implications for a broad category. Several ideas for broad categories had already formulated from the reading of the transcripts, and in the unitising process, the researcher typed the broad category title in the margin. For example "Support" was an initial broad category. Within the text the researcher made any theoretical notes or notes concerning overlap of categories as an aide memoir for future reference. Three or four transcripts were handled in this way before a review of the broad categories was undertaken. It was necessary to ensure that the broad categories developed were internally homogeneous and externally heterogeneous. It was clear that they were not, and so the researcher wrote out the categories, and their characteristic components, or their properties, and by re-working and changing the label of categories, and amalgamating others, the initial 11 categories became 7. By amalgamation, certain sub-categories were becoming obvious, and the researcher shared some of the data with another researcher which helped clarify some of the categories. Feeling more confident of the seven broad categories the researchers then went through each transcript, unitising, and then cutting and pasting into seven broad category sub-files. In this way the units that apparently related to the same content, were brought together. Any data which did not 'fit' into one of these sub-files went into a miscellaneous file for subsequent re-categorising. Each sub-file therefore contained data from the twenty interviews pertinent to a particular category. These were then read and re-read to ensure that the categories were robust, and mutually exclusive. Rules were devised to describe category properties and to render the category internally consistent. They were then subjected to further unitising and labelling in the margins to determine the sub, and sub-sub categories. The set of categories were subsequently examined for possible relationships among categories ('pattern matching') and the categories were accordingly refined.

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2. 4 . DATA GENERATED FROM TEACHERS, PRACTITIONERS AND MANAGERS

Data Collection Method

The data collection method of choice for all of these three groups of participants was the focus group interview. Focus group interviews are 'group discussions organised to explore a specific set of issues and the group is focused in the sense that it involves some kind of collective activity' (Kitzinger 1994:101). The reliance is on interaction within the group based on topics that are supplied by the researcher as moderator (Morgan 1988). Their merits were felt to be in the opportunity they afforded to observe a large amount of interaction on a topic in a limited amount of time (Morgan 1988), and in providing the opportunity for an exploration of 'differences' in situ with the help of other participants (Kitzinger 1994). Similarly the opportunity afforded to thematically identify a diversity of viewpoints and a range of behaviour patterns (Jarrett 1993) associated with the philosophy and practice of nursing was felt to be very valuable. A further strength of focus groups in an uncharted area of research was identified in their ability to explore new topics and generate hypotheses with little input from researcher (Morgan 1988).

Sample

For all the focus groups it was felt to be important that the participants were peers, and were all of the same hierarchical level within the organisation, as homogeneity of the group acts as an encouragement for all to express strong opinions or ideas. (Folch-Lyon & Trost 1981) That is if there are different hierarchical levels within the group it may be "too professionally risky to disagree" (Albrecht et al 1993). A situation the research team were keen to avoid. A range of opinion within the groups was sought, and this was conveyed to all potential participants. As a safety net each focus group participant was asked if the views expressed represented the opinions of other colleagues not present.

Teacher Sample

The teacher samples as a whole and for each focus group reflected the different branch programmes where possible, and all participants had a good working knowledge of Project 2000 students and of the course. The majority had also taught on previous RGN courses and this was felt to be beneficial, enabling some comparisons to be made. Teachers were invited to participate in the focus group discussions by personal letter (Appendix 17). In centre one, there were eight participants, and in centre two there were seven participants. See below for sample characteristics.

Practitioner Sample

The practitioners were all at ward sister level (grades F and G), and had all worked with both Project 2000 students and their traditional counterparts. Some had also worked with qualified Project 2000 nurses. Practitioners were invited to participate in the focus group by initial telephone call and follow-up confirmatory letter (Appendix 18). Two focus group discussions were held, one in each centre. In centre one there were twelve participants and in centre two there were nine. Further details of the work areas and demographic characteristics of this sample are given below.

Manager sample

The managers were those who managed the ward sisters, but their titles varied from trust to trust and from speciality to speciality. Managers were invited to participate in the focus group by initial telephone call and follow-up confirmatory letter (Appendix 19). They had all worked with Project 2000 students, and many with Project 2000 qualified nurses (not the community managers). Similarly they had previously worked with traditional students and qualifiers and so were able to offer comparisons. Two focus group discussions were undertaken, one in each study centre. There were eight participants in centre one and seven in centre two. See below for further sample breakdown.

Sample Characteristics

Teacher Sample

Table 4 below illustrates the areas of speciality of each of the focus group members:

Table 4 :Teacher Focus Group Participants

Centre 1	Centre 2
13.7.94. [8 participants]	1.6.94. [7 participants]
1 paediatrics 1 mental health 2 community 1 community (L. Disability) 3 CFP / Adult	1 orthopaedic /trauma 2 mental health (community) 2 medicine / surgery 1 Macmillan/palliative 1 ITU/CCU

Appendix 20 gives further breakdown of the teacher samples in terms of educational speciality, age, educational qualifications and background of participants.

Practitioner sample

Table 5 below illustrates the areas of speciality of each of the focus group members:

Table 5 :Practitioner Focus Group Participants

Centre 1	Centre 2
7.12.94. [12 participants]	30.11.94. [9 participants]
1 surgery 1 urology 1 health visitor 2 district nurses 2 mental health 1 paediatrics 1 dialysis 1 vascular 1 neurology 1 orthopaedics	1 gynaecology 1 theatres/recovery 2 health visitors 1 district nurse 2 mental health 1 learning disabilities (community) 1 medicine

Appendix 21 gives further breakdown of the practitioner samples in terms of educational speciality, age, qualifications and background of participants.

Manager sample

Table 6 below illustrates the areas of speciality of each of the focus group members:

Table 6 : Manager Focus Group Participants

Centre 1	Centre 2
5.12.94. [8 participants]	20.10.94. [7 participants]
1 surgery 2 paediatrics 1 mental health 1 community 1 burns and plastics 1 medicine (NDU) 1 cardiothoracic	1 orthopaedics/trauma 1 paediatrics 1 mental health 2 learning disabilities (community) 1 elderly 1 medicine

Appendix 22 gives further breakdown of the manager samples in terms of educational speciality, age, qualifications and background of participants.

Data Collection Tool

BEST COPY AVAILABLE

A topic guide was developed to reflect the aims and objectives of the study. Although each guide was similar for each set of participants there were some differences to reflect the differing aims for each group of participants (see appendix 23). The schedule was only utilised as a guide, and provided a focus for the discussions to the participants. Thereafter the agendas of the participants were followed within the limitations of the study aims.

Pilot Work

One pilot focus group was undertaken with nurse teachers in a London college of nursing. There were six participants, and it was felt to be particularly useful for the researchers to test both the schedule, and the method. The group was tape recorded, and a preliminary content analysis was undertaken to ensure that the aims of the study were being met by the group.

Main Study Data Collection

Generally the research team were already known to the teacher focus group participants from negotiating access to the student population. The sample for the teacher focus groups was identified initially by the key contact in each centre, and then individuals were approached. (see above).

Managers and practitioners were again often initially identified by the senior service side contact person in each trust, but as the researchers contacted the potential participants by telephone, people would informally recommend colleagues. Each participant then received a follow-up or initial letter if they were difficult to contact by telephone by letter and the focus group interviews were arranged at mutually convenient times.

The researchers were keen to maintain flexibility within the group, and for the data to emerge from the participants with minimal guidance and interference. The schedule was therefore utilised as a guide only. It was felt to be important that both researchers were present at all focus groups. Generally one took the role of principal moderator, whilst the other kept field notes, recorded participants ideas on the flip chart (particularly important in the initial 'brainstorming') and picked up any probes and cues as necessary. All focus group interviews were tape recorded, and transcribed verbatim.

Data Analysis

Each focus group discussion was audio taped and transcribed verbatim. The initial analysis process consisted of listening to each audio tape whilst simultaneously reading the discussion transcript. In this way any gaps or inaccuracies were picked up and amended. Similarly verbal signs of agreement were noted to indicate consensual support. The corrected transcripts were then coded into topics utilising the discussion guidelines as an initial framework. Preliminary codes were written on the transcripts in the margin, and the transcripts were cut and pasted on the Macintosh into topic files to collate the data within participant groups. An initial overview grid (Morgan 1993) was compiled for each topic, utilising thematic induction with the topics. These themes were those issues which received general support together with isolated issues, and these were consistent across participant groups. Illustrative quotes for each theme were identified and added to the thematic files.

Presenting The Data

Organising the data and deciding which parts of the interviews and questionnaires to use was challenging, and inevitably some data had to be omitted. These limitations had to be accepted, as no overall analytic structure can encompass all the analysis and empirical material (Lofland 1971). In the process of writing up it was considered important to use quotes from the actual transcripts and questionnaires to illustrate the categories and points made. Each extract has the participants identification number and the transcript page from where it was taken. At times it was necessary to edit some of the conversation, to improve the flow. Where this has been done it is indicted in the text by (....). As the majority of the sample were women, the pronoun 'she' is used to mean all nurses in the sample. Similarly whilst it is acknowledged that ward managers, may be either ward sisters or charge nurses and be of either gender, the term 'ward sister' is used throughout to represent either post and the pronoun 'she' is used to mean all ward managers.

2. 5. RESEARCH STRATEGY AND METHODS: OVERALL SUMMARY

Data were collected from five different groups of participants utilising three different methods. Four cohorts of students in each study centre were accessed in the college of nursing. Each student was asked to complete a questionnaire at three different time points (at nine monthly intervals). Two cohorts within each centre qualified within the life of the project, and these newly qualified practitioners were asked to complete postal questionnaires at six months post qualification. These diplomates were also invited to participate in a one to one in-depth interview. Ten diplomates in each centre were selected for these unstructured interviews with a member of the research team.

Data from the teachers, practitioners and managers were collected at focus group interviews. Each focus group consisted of between six and twelve people. Two groups were facilitated with teachers, two with practitioners and two with managers.

Chapter 3:

Project 2000 and the Perceptions of the Philosophy and Practice of Nursing:

The Students' Tale

INTRODUCTION

The focus of this chapter is the analysis of the data pertaining to the students' perceptions of the nature and discipline of nursing. The findings presented inform a main aim of the study, namely an examination of the extent to which students' perceptions may change over the period of their Project 2000 course. The data also illuminate students' perceptions of themselves as professional practitioners and of their future contribution to health care. In addition the data offer some insights into their experiences of the process of professional socialisation.

These data are derived from an analysis of over 1200 questionnaires completed by 498 students from two case study centres at different time points during and after the Project 2000 course. Each student was given the opportunity to complete three questionnaires at different time points. Full details of data collection and cohorts can be found in Chapter 2.

The findings presented in this chapter offer a unique insight into the perceptions, beliefs and experiences of a large group of 'new nurses'. Overall these perceptions do seem to change over time to a greater or lesser extent, and an attempt has been made throughout the text to indicate the pattern of change and, in particular, to identify those changes which appear to be most significant. As discussed in chapter 2 statistical analysis has been undertaken where appropriate. It is important to acknowledge here that no students were followed from the beginning to the end of the course. The period available for data collection was eighteen months, and this was spread across cohorts to achieve data from the start of the course to six months post qualification (see table 1). Therefore the qualified nurses at the end of the course are from a different cohort / sample than those at the start of the course.

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The findings from the data analysis relating to students' perceptions are presented in this chapter under three main sections as follows:

1. **Demographic data**
2. **Changing perceptions of the nature and discipline of nursing**
3. **Students' perceptions of the Project 2000 course as a preparation for professional practice and socialisation into the professional role.**

3. 1. DEMOGRAPHIC DATA

Demographic data were collected from the eight cohorts of students within the two study centres at the initial point of contact. The initial contact point varied depending on the cohorts. As can be seen from table 7 cohorts 4 (centre 1) and 8 (centre 2) were first accessed at point A (beginning of the course). Cohorts 3 (centre 1) and 7 (centre 2) at access point B (9 months) and cohorts 1 & 2 (centre 1) and 5 & 6 (centre 2) were accessed at time point D (27 months). The demographic details at each access point are presented below in table 7.

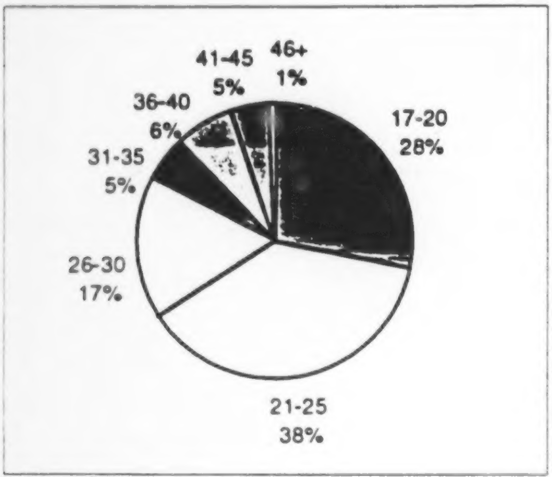
Table 7: Demographic characteristics of the total sample

Access Points	A Cohorts 4 & 8		B Cohorts 3 & 7		D Cohorts 1 2 5 & 6		TOTAL	
	n	%	n	%	n	%	n	%
AGE								
17-20	69	44%	46	41%	15	8%	130	28%
21-25	34	22%	25	23%	99	52%	158	34%
26-30	23	15%	11	10%	34	18%	68	15%
31-35	12	8%	7	6%	14	7%	33	7%
36-40	10	6%	10	9%	14	7%	34	7%
41-45	6	4%	9	8%	11	6%	26	6%
46+	3	2%	3	3%	4	2%	10	2%
Missing	0	0%	0	0%	1	1%	1	0%
GENDER								
Male	23	15%	7	6%	41	21%	71	15%
Female	134	85%	104	94%	151	79%	389	85%
Missing	0	0%	0	0%	0	0%	0	0%
BRANCH								
Adult	113	72%	81	73%	163	85%	357	78%
Mental health	23	15%	12	11%	26	14%	61	13%
Learning disabilities	0	0%	6	5%	0	0%	6	1%
Child	15	10%	9	8%	3	2%	27	6%
Missing	6	4%	3	3%	0	0%	9	2%
QUALIFICATIONS								
A' levels	45	29%	33	30%	57	30%	135	29%
Diploma	6	4%	17	15%	10	5%	33	7%
Degree	8	5%	2	2%	8	4%	18	4%
GCSE	67	43%	43	39%	93	48%	203	44%
None/Access	9	6%	12	11%	14	7%	35	8%
Other higher ed.	15	10%	3	3%	9	5%	27	6%
Nursing related qual	6	4%	0	0%	0	0%	6	1%
Missing	1	1%	1	1%	1	1%	3	1%
PREVIOUS WORK								
Caring, non-nurse related	24	15%	15	14%	19	10%	58	13%
No previous work	5	3%	5	5%	5	3%	15	3%
Caring, nurse related	61	39%	33	30%	74	39%	168	37%
Other work	47	30%	41	37%	79	41%	167	36%
Parent	2	1%	2	2%	1	1%	5	1%
Previous student nurse	11	7%	7	6%	11	6%	29	6%
Missing	7	4%	8	7%	3	2%	18	4%

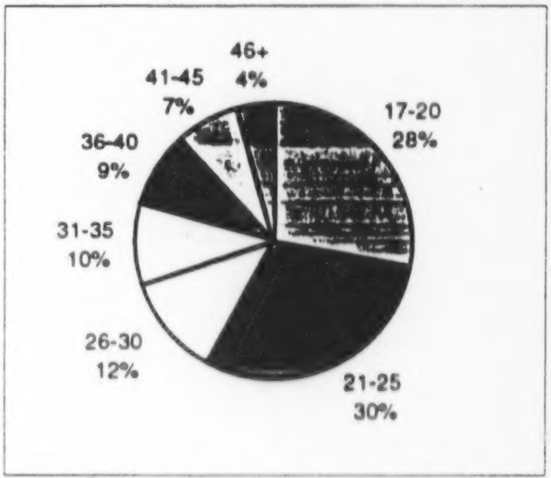
*N.B. Some students were not accessed at Points A, B and D when demographic details were collected. See Appendix 10 for details of completed questionnaires.

The demographic characteristics were remarkably similar between cohorts, as were samples at different access points and samples between centres. The demographic characteristics of the total sample, by centre are presented below in pie charts. As can be seen the ages of the respondents were similar, although centre two had a greater proportion of students in the over 40 age range.

Age of Respondents



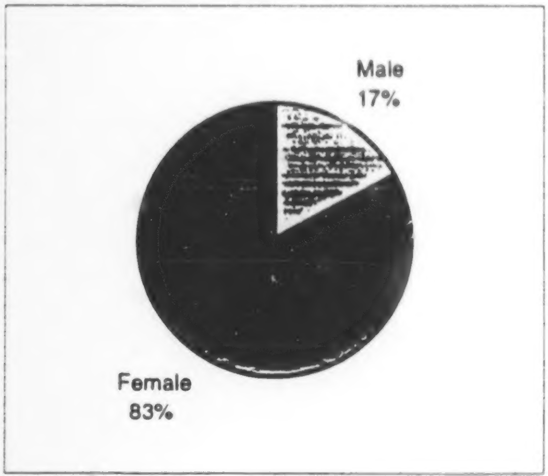
centre 1



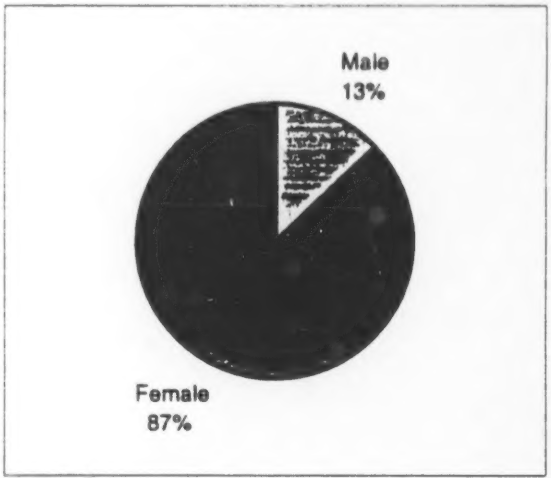
centre 2

In both study centres over three quarters of students were female, with centre one having slightly more male students than centre two.

Gender of Respondents



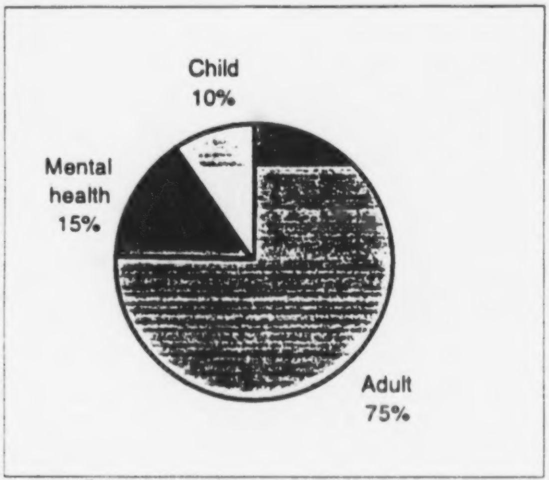
centre 1



centre 2

Three quarters or more of students in both centres were undertaking the adult branch programme. centre one did not offer the learning disabilities course, whilst centre two did not offer the child branch. One quarter of students in centre one were undertaking branches other than adult, whilst this proportion was only 13% in centre two.

Branch



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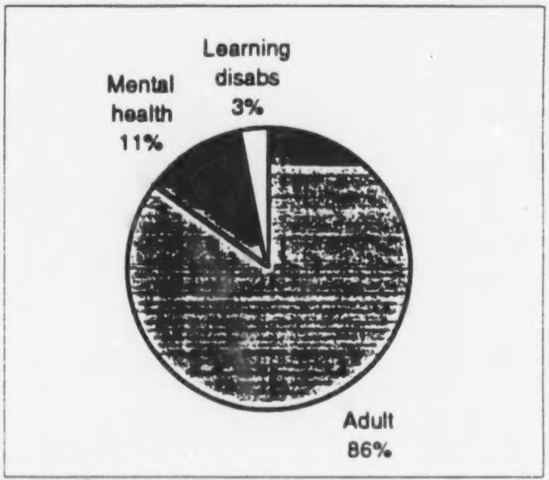
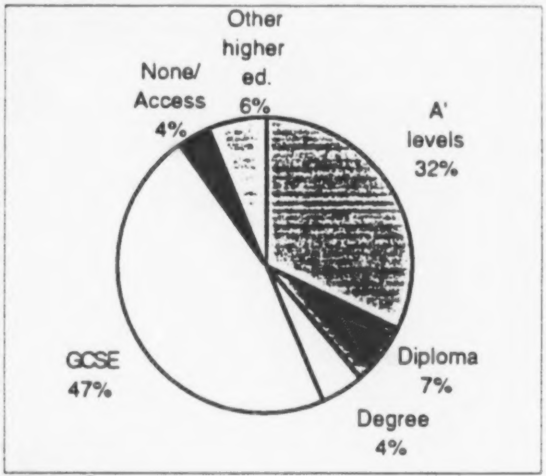


centre 2

The highest educational level attained by the majority of students in both centres was GCSE. Slightly fewer students had A level qualifications in centre two than in centre one, whilst centre two had more students entering the course through the access route who possessed few or no formal qualifications. This is consistent with the fact that there were a greater number of mature entrants in centre two.

Qualifications



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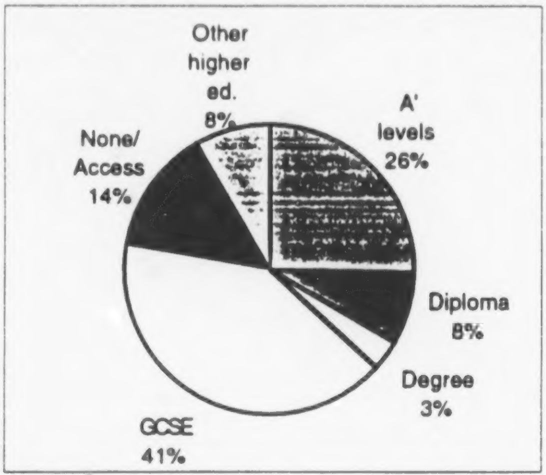
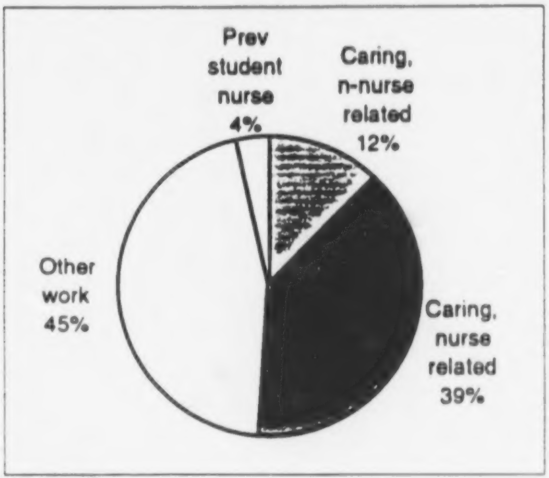


centre 2

The previous work experience of the students in the two centres was also remarkably similar, with over one third of students having some nursing related experience (e.g. previous nursing auxiliary). A greater proportion of students in centre two than centre one had previously commenced a student nurse training programme.

Previous Experience



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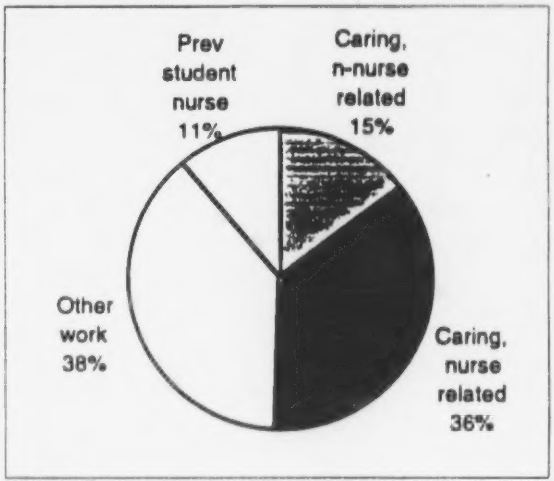

centre 2

To summarise, there were few demographic differences between centres and there were also few differences in questionnaire responses between centres. Therefore the descriptive data in the rest of this chapter have for the most part been collapsed across the two centres. Where differences between centres exist these are noted when appropriate in the text.

Questionnaire Response Rates

Students were accessed at six different time points across the course and each student had an opportunity to complete three questionnaires, at three different time points, nine months apart. The response rates to the questionnaires are presented in table 8 below, at each of the six access points, A to F.

Table 8: Access points and questionnaire response rates

Access Point	Start of course A	9 mths into course B	18 mths into course C	27 mths into course D	36 mths into course E	6 mths after end of course F
Jan '91 Intake Cohort 1, centre 1 n=90				82% n=74(90)	70% n=63(90)	31% n=28(89)
Cohort 5, centre 2 n=37				92% n=34(37)	89% n=33(37)	41% n=15(37)
May '91 Intake Cohort 2, centre 1 n=90				69% n=62(90)	55% n=49(89)	27% n=24(89)
Cohort 6, centre 2 n=25				92% n=23(25)	92% n=23(25)	44% n=11(25)
Sept/Oct '92 Intake Cohort 3, centre 1 n=84		48% n=57(84)	41% n=35(78)	39% n=31(78)		
Cohort 7, centre 2 n=78		72% n=56(78)	80% n=56(70)	63% n=43(68)		
Mar/May '93 Intake Cohort 4, centre 1 n=91	98% n=89(91)	73% n=62(86)	70% n=67(86)			
Cohort 8, centre 2 n=70	97% n=68 (70)	92% n=61 (66)	94% n=50 (53)			

NB: There were small changes in sample size across the different access points for each cohort, this was because whilst some people may not have completed all three questionnaires, additional people were recruited into the study from the original sample (i.e. the cohort as a whole). For a further breakdown of the attrition rates, and sample gains see appendix 10.

Presentation of Findings

The questionnaires were designed to elicit either open-ended responses, yes / no responses, or responses to four point scales. Data have therefore been presented both in tabulated form and, where relevant, through the use of descriptive exemplars taken directly from students' quotes. All tabulated data present the percentage frequency by respondents i.e. the proportion of respondents who offered a response in each category. Each table in the text also reflects the time points at which the data were collected. These time points are labelled A to F to chronologically reflect the six different questionnaires A to F. Most questions were repeated across questionnaires at selected time points, whilst a few were included at all six time points. The majority of the questionnaire F data have been

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presented in chapter 4 as it pertains most directly to the views of the qualified diplomates. However, some of the data from these questionnaires were also presented in this chapter where it offers a basis for comparison with the views expressed by the students on the course. The data have been presented adjacently in tables to illuminate consistency or changes in response over time. As discussed previously data from each case study centre were analysed separately but few differences in response were detected. The majority of tables present combined data sets. Where marked differences emerged individual centre responses are identified.

The presentation of the questionnaire data in this chapter has attempted to organise and order a large set of responses. Appendix 24 details an overview of the questions, and at which time points they were asked, and appendix 11 gives further detailed breakdown of exemplars of categories from some of the tabulated data.

An overview of questionnaire findings is now presented under two sections related both to students perceptions of nursing over the period of their Project 2000 course and secondly the contribution of the course as a preparation for practice, and socialisation into the professional role.

3. 2. STUDENTS' PERCEPTIONS OF THE NATURE AND DISCIPLINE OF NURSING

As will be seen, analysis of the questionnaire data revealed a clear consensus from the students about the nature and discipline of nursing. Some changes over time did emerge but all respondents were committed to delivering high quality care and were often fierce proponents of patient advocacy. There was a strong focus on the centrality of the patient and the principles of basic nursing care, caring and holism.

It is important to note that there may be a difference between an individual nurse's 'philosophy' of nursing and his / her understanding of nursing gained through enhancing theoretical knowledge during the course. Students certainly entered the course with lay perceptions of nursing and these perceptions changed as the course progressed. However, it is not possible from this study to determine the full extent to which the principles of nursing gained from the course were internalised. Further research would be required to explore this in more depth.

Patient Centredness and Holism

Students were asked to define nursing care (Q016), asked at time points 'A to E' inclusive. Nursing care was perceived as being very patient orientated, both in terms of care giving and in partnership. Taking a holistic perspective was a common thread, but appears to increase significantly in perceived importance by the end of the course. Respondents also identified the value of seeing the patient in context, not just as an ailment, together with caring for the families of the patient. Seeing nursing from the perspective of "nursing the sick" decreased significantly over time as the course progressed, whilst the caring perspective increased significantly, as demonstrated in table 9 below.

Table 9: Q016 What do you understand by the term nursing care?

Questionnaire:	A (Start)		B (9 months)		C (18 months)		D (27 months)		E (End)	
Category	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
Patient orientated	48	31%	89	38%	69	36%	119	45%	58	41%
Caring*	37	24%	65	28%	30	16%	147	55%	69	49%
Facilitate recovery	36	23%	48	21%	58	30%	55	21%	19	13%
Nursing the sick*	34	22%	43	19%	36	19%	25	9%	6	4%
Holism*	28	18%	71	31%	50	26%	96	36%	70	49%
Practical work	21	13%	30	13%	15	8%	41	15%	21	15%
Apply theory to practice	19	12%	27	12%	22	11%	34	13%	16	11%
Anything a nurse does	15	10%	21	9%	35	18%	31	12%	30	21%
Health education/promotion	12	8%	29	13%	22	11%	26	10%	3	2%
Inter Personal Skills	6	4%	9	4%	5	3%	21	8%	5	4%
Care in community	5	3%	10	4%	5	3%	9	3%	7	5%
Quality care	4	3%	16	7%	6	3%	16	6%	5	4%
Non-judgmental	3	2%	4	2%	1	1%	7	3%	0	0%
Team orientated	3	2%	0	0%	2	1%	12	5%	4	3%
Personal qualities	1	1%	0	0%	0	0%	4	2%	0	0%
Other	4	3%	5	2%	6	3%	9	3%	0	0%

Total responses	276	467	362	655	313
Total respondents	156	232	193	265	142

* Using the test of differences between proportions to compare the proportion of answers in these categories at point A (start) and point E (end) these changes over time were found to be significant at the $p < 0.001$ level.

As a student twenty-seven months into the course suggested, nursing care is the:

> *"holistic care for the individual, either sick (in hospital/home) or well (health promotion and prevention), and their significant others. Encompasses spiritual, emotional, social and physical needs of client and supporters. Also, encouraging individuals to take responsibility for their own well - being i.e. empowerment."* [111403]

Students were asked both to define the term holistic care (Q 027), and were also asked to comment on its importance to nursing practice (Q 028). The students appeared to have no difficulty in articulating their understandings of the term holistic care and at all access points of the course over 90% felt that it was important to nursing practice. It was clearly something instilled in them through the course. For example holistic care was seen as:

> *"Something every lecturer mentions at least once a lesson during the first 18 months!"* [261413]

Respondents clearly recognised holism as considering the patient/client as a whole, not just as an illness and suggested that issues cannot be viewed in isolation and all affect each other. As a student at the end of the common foundation programme reflected, holistic care is:

> *"To care for the whole patient and not just the illness. To see a patient as a whole with different needs and strengths who needs to respond to his social surroundings, background and to family etc."* [141378]

Another student at the end of the course suggested holistic care was important because:

> *"'patients in hospital are not just, for example 'The man in six with the leg' its 'Bob in six, with the leg, who can't work for 6 weeks whose families depend on his income because he is self employed.' To care for the patients we must examine them as holistic beings. "* [251513]

Some students could see that holistic care was a move away from the reductionist medical model of care towards an exploration of the whole, which may include underlying or hidden problems thus contributing to a fuller recovery. As a student twenty-seven months into the course commented:

> *"Nurses are in a position to compensate for the medical reductionist stance that continues to pervade in the medical profession - many factors influence an individual and ill health may be the last effect in a chain of causes and effects that*

> *began with something that is seen to be quite irrelevant to medicine. Nurses are in a position to draw out and identify such features and help / empower clients to rectify matters."* [111447]

Embracing Basic Nursing Care

Across all questionnaire points the vast majority of respondents felt that qualified nurses should give high priority to basic nursing care (Q 048). At D and F, this proportion increased to over 90%. Statistical analysis performed on the four point scales suggest, that students increasingly valued basic nursing care once in the practice environment as illustrated in table 10 below:

Table 10: Q048 What priority should a qualified nurse give to basic nursing care (BNC)?

Questionnaire:	B (9 months)		C (18 months)		D* (27 months)		E (end)		F (6 months post)	
Category	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
High	192	88%	174	91%	244	95%	117	87%	72	95%
Low	27	12%	17	9%	14	5%	17	13%	4	5%
Total	219	100%	191	100%	258	100%	134	100%	76	10[illegible]

* Kolmogorov-Smirnov test revealed a significant difference over time in the value placed on basic nursing care between B and D ($p<0.05$).

From table 11 it can be seen that the open ended comments revealed that respondents felt basic nursing care to be the 'bedrock of nursing', and that it is important to be patient focused.

Table 11: Q048 What priority should a qualified nurse give to basic nursing care (BNC): Comments?

Questionnaire:	B (9 months)		C (18 months)		D (27 months)		E (end)		F (6 months post)	
Category	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
Important to patients/patient focused	65	54%	42	36%	81	43%	24	29%	13	25%
Foundation of all care/"bedrock of nursing"	22	18%	37	32%	72	38%	31	37%	16	30%
Low priority	13	11%	13	11%	17	9%	7	8%	9	17%
Structural/wider issues prevent BNC by qualified nurses*	11	9%	8	7%	25	13%	8	10%	16	30%
Opportunity to build relationships/communicate*	8	7%	16	14%	35	19%	10	12%	24	45%
Promotes independence/ prevents complications	5	4%	9	8%	9	5%	1	1%	1	2%
Other high priority	5	4%	0	0%	5	3%	11	13%	15	28%
Total responses	129		125		244		92		94	
Total respondents	120		117		188		84		53	

* When B and F responses were compared using a test of differences between proportions they were found to be significantly different ($p<0.001$)

Changes across access points can also be identified from this table. The "importance of basic nursing care to patients" category diminishes over the course, whilst "providing an opportunity to build relationships and communicate with patients" increases significantly between points B and F. This may reflect how the newly qualified nurses' felt about being removed from the bedside and having reduced opportunities to communicate with patients. Structural and wider issues also increase significantly from A to F, and were perceived to prevent the qualified nurse taking on this bedside role. There was a recognition by some that more resources would be required to ensure that qualified nurses rather than health care assistants undertook this role. Twice as many qualified Project 2000 nurses (at F) compared to those at (C) recognised the importance of resource constraints upon their role in the provision of basic nursing care. Respondents from centre 2 largely, consistently rated structural constraints higher than those in centre 1. A newly qualified staff nurse in centre 1 commented:

> *"Basic nursing care is essential in delivering holistic care to patients and is often the best time for communication, education, counselling etc. At times when the ward is busy and the unqualified provide all basic nursing care as the qualified nurse(s) is busy, e.g. administering drugs, infusions, etc. The qualified nurse can miss very important aspects of patient care despite non-qualified staff reporting to her, i.e. deterioration in skin condition, worries/anxieties at home etc."* [121622]

Whilst another in centre two suggested basic nursing care was important if qualified nurses were to be more than managers of care:

> *" If basic nursing care is thought of as an HCAs job then there is no point training staff nurses in the role as anything except managers. Qualified nurses are ultimately responsible for the case delivered to patients and this can only be assessed properly if the nurse is involved in basic nursing care herself. Basic nursing care is when a rapport is established/built on, further needs are identified and good re-evaluation of care can take place."* [261617]

The small minority who considered basic nursing care should be "low priority" suggested it was the role of health care assistants, as in the following example:

> *"I feel basic nursing i.e. bed bathing etc. should be given by HCA as nurses are trained at the cost of £30000. Their skills should be used for more important things."* [271217]

Valuing Research

Students at access points B to E were asked about the importance of nursing research to nursing practice (Q 029). Research was deemed important to nursing practice by over 90% of students both across centres and all the different access points through the course. Statistical analysis was undertaken on the four point scale data using the Kolmogorov Smirnov test. The results indicated that there was a significant difference between answers at B and D ($p<0.001$) and between C and E ($p<0.001$). Research was seen as increasingly important as the course progressed. Reasons for its importance to nursing included the facilitation of quality care, the reduction of rituals and enhanced professionalism. As a student half way through the branch programme commented:

> *"(research) leads to improvement in professional practice. Move away from 'this is how we've always done it'. Drive towards professionalism."* [271444]

Research was valued for the framework it provided for care. It was seen to provide a rationale for nursing practice and to reduce routinisation. A student nine months into the course suggested:

> *"Traditional practices can be proved to be of no use and only research can disprove the benefit of certain practices, e.g. rubbing bottoms to prevent bedsores was practised for years and finally proved to be more damaging than not rubbing them."*[145108]

Over 70% of students at the end of the common foundation programme and more than 80% by the end of the course suggested that they had had an opportunity to relate a research finding to practice (Q30). The most common examples given related to infection control, pre-operative care and pressure area care. A student in centre two about to commence the branch programme reflected:

> *Yes - I was shown how to do a bladder wash out by a health care assistant which wasn't aseptic. I went on to discover that it should be an aseptic technique so I looked at research to find out why and how important it is that bladder wash out is performed aseptically."* [281141]

However only 65% of the qualifiers (F) suggested that they were able to implement research. Resource and structural constraints were seen to be the biggest barrier. In addition little time to read research, together with staff shortages were implicated. As one diplomate working in a private nursing home commented:

> *"Nurses don't want to change their methods, particularly the matron e.g. pressure sores. Their argument is, well it costs too much!"* [111632]

Good Nursing and Good Nurses

Students were also asked to consider the concept of 'good nursing care' (Q 017). This question was asked to all students at access points A to E and to the newly qualified nurses at F. When considering what was required for good nursing care, a caring, patient orientated approach was again seen as essential. Communication and inter-personal skills were consistently valued by students in both centres and across all access points (See table 12 below).

Table 12: Q017 What do you think is required for good nursing care?

Questionnaire:	A (Start)		B (9th months)		C (18 months)		D (27 months)		E (End)		F (6 mths post)	
Category	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
Patient orientated	95	61%	140	61%	110	57%	158	61%	85	61%	39	51%
Personal qualities	87	55%	103	45%	74	38%	135	52%	54	39%	36	47%
Caring*	76	48%	107	46%	76	39%	107	41%	41	29%	23	30%
Inter Personal Skills	73	46%	143	62%	126	65%	172	66%	92	66%	47	62%
Knowledge of nursing theory	56	36%	90	39%	107	55%	158	61%	87	62%	47	62%
Non-judge philosophy	36	23%	70	30%	31	16%	60	23%	30	21%	16	21%
Organisation & resource issues*	33	21%	31	13%	22	11%	77	30%	35	25%	38	50%
Professional issues	31	20%	36	16%	21	11%	60	23%	31	22%	16	21%
Practical base/skills	27	17%	69	30%	64	33%	73	28%	47	34%	24	32%
Team orientated	26	17%	29	13%	35	18%	47	18%	17	12%	7	9%
Health education/promotion	5	3%	14	6%	5	3%	10	4%	6	4%	2	3%
Lifelong learner	4	3%	1	0%	2	1%	0	0%	0	0%	0	0%
Research based practice	2	1%	15	6%	18	9%	21	8%	12	9%	13	17%
Other	3	2%	8	3%	7	4%	0	0%	0	0%	1	1%
Total responses	554		856		698		1078		537		309	
Total respondents	157		231		194		261		140		76	

* Using the test of differences between proportions to compare the proportion of answers in these categories at point A (start) and point F (six months post) they were found to be significantly different ($p< 0.01$) and ($p< 0.001$) level respectively.

As seen from table 12 above the relative value of caring decreased significantly whilst the importance of organisational and resource issues increased significantly by the end of the course. Students at the end of the course and newly qualified nurses appear to realise the importance of good resources. Motivated, well trained staff with a good skill mix in particular were seen to be crucial, moreover a sound theoretical knowledge base assumed more importance as the students progressed through the course. A student twenty-seven months into the course suggested that the following were all important for good nursing care:

> *"Understanding of medical condition. Understanding of contributing factors, i.e. social, cultural, spiritual, psychological and environmental. Interpersonal skills. To respect the patients' wishes and accept their choices whether good or bad. To be able to give correct and informed information. To ask for help whenever necessary, i.e. if you do not have the necessary knowledge or skills."* [271247]

Desirable qualities of student and qualified nurses

Students were asked to identify five qualities of a 'good' student nurse, at all time points from A to E inclusive (Q022). Inter-personal and communication skills were valued by students in both centres and at all access points on the course. The findings from the comments section of this question have been categorised in table 13:

Table 13: Q022 What five qualities do you think a good nursing student possesses?

Questionnaire:	A (Start)		B (9 months)		C (18 months)		D (27 months)		E (End)	
Category	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
Personal qualities	124	79%	180	76%	157	77%	210	80%	116	81%
Ability to learn	103	66%	145	61%	138	68%	195	74%	107	75%
IPS/communication	95	61%	157	66%	131	65%	162	61%	89	62%
Caring attitude	69	44%	102	43%	92	45%	98	37%	34	24%
Professional issues	45	29%	62	26%	38	19%	89	34%	52	36%
Non-judgmental approach	41	26%	65	27%	49	24%	56	21%	33	23%
Patient orientated	37	24%	51	22%	50	25%	51	19%	34	24%
Thirst for change	26	17%	62	26%	45	22%	87	33%	46	32%
Team orientated	18	12%	12	5%	20	10%	32	12%	18	13%
Practical skills	14	9%	37	16%	26	13%	20	8%	12	8%
Research aware	2	1%	6	3%	8	4%	12	5%	4	3%
Other	2	1%	6	3%	1	0%	8	3%	3	2%
Total responses	576		885		755		1020		549	
Total respondents	156		237		203		264		143	

Students were also asked to identify five qualities of a "good" qualified nurse (at all time points from A to E - Q 045). The findings from the comments of this question are presented below, in table 14.

Table 14: Q045 What five qualities should a 'good' qualified nurse possess?

Questionnaire:	A (Start)		B (9 months)		C (18 months)		D (27 months)		E (End)	
Category	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
Personal qualities	109	72%	148	67%	124	67%	170	66%	81	59%
IPS/communication	82	54%	140	63%	131	71%	175	68%	102	74%
Caring*	80	53%	126	57%	87	47%	75	29%	28	20%
Nursing knowledge	72	48%	112	51%	95	51%	139	54%	74	54%
Professional skills*	63	42%	94	43%	78	42%	168	65%	98	71%
Professional development	52	34%	55	25%	37	20%	51	20%	28	20%
Empathy/sympathy*	50	33%	61	28%	49	26%	0	0%	0	0%
Non-judgmental	35	23%	48	22%	41	22%	50	19%	15	11%
Organisation/management	34	23%	52	24%	45	24%	84	33%	42	30%
Team orientated	25	17%	35	16%	31	17%	49	19%	19	14%
Patient orientated*	18	12%	34	15%	32	17%	102	40%	60	43%
To challenge	8	5%	13	6%	15	8%	25	10%	16	12%
HE/HP	4	3%	4	2%	6	3%	0	0%	0	0%
Total responses	632		922		771		1088		563	
Total respondents	151		221		185		258		138	

* Comparing the proportion of answers in these categories at point A (start) and point E (end) they were found to be significant (p< 0.001) using the test of differences between proportions.

As can be seen from table 14 above, 'personal qualities' and 'interpersonal skills/communication' are valued across all time points. Personal qualities (e.g. sincerity, sense of humour, honesty, conscientiousness) appear to diminish in importance across access points A and E whilst interpersonal skills and communication increase slightly. A more marked change over time however, can be perceived in the increased importance of 'professional skills' and 'patient orientation'. Both increase in perceived importance across access points A to E, so that by the end of the course

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professional skills (e.g. practical skills, teaching skills, professionalism) is the second most frequently cited response after interpersonal skills. Caring however, diminishes significantly across access points and is more frequently cited at A, B and C than at D and E. Similarly, empathy/sympathy also significantly declines from A, B, and C to D and E where it is not cited at all.

Health Promoters by any other name

Explicit in the philosophy underpinning Project 2000 is the shift in emphasis in nursing, from illness to health and the increasing emphasis in the health promotion role within nursing. The data collected indicate that the concepts of health education and health promotion were in general poorly understood. Although at a different level aspects could be found embedded in the students' understandings of nursing, these were not labelled health education/ promotion, but rather emerged from understandings of the concept of holism.

When asked if they would make a distinction between the terms health education and health promotion (Q 018) over 80% of students across all access points (A to E) agreed they would. However, when it came to articulating the differences between the concepts, the responses were characterised by confusion. The majority perceived a difference in the application of the terms, with health promotion generally seen as 'broader'. There was a tendency for both terms to be regarded as lifestyle related, and concerned with behaviour change. A student at the beginning of the course suggested:

> *"**health education** is to educate people to correct bad practice. To teach people about their own bodies and to appreciate how they work and what they need." **health promotion** is to promote 'good' health i.e. not smoking, reducing alcohol, sensible eating."* [281104]

Some students had grasped the wider aspect of healthy policies that many consider equate with the term health promotion (e.g. Tones 1990, Latter 1995). These were very much in the minority (2% of respondents at C, B &E, and 3% at A and D). These responses were often well articulated however, as a student at the beginning of the course reflected:

> *"**health education** is providing information about health issues to individuals or groups; a persuasive way of informing people what is the healthy choice. **health promotion** is health education plus using your influence as a nurse to try to change environments which cause ill health - lobbying council etc."* [281107]

Similarly, a student at the end of the common foundation course suggested:

> *"**Health Education**: For example, teaching a newly diagnosed diabetic on his/her condition.*
> ***Health Promotion**: Encouraging clients to campaign for better housing, or acting as their advocate."* [142379]

Implicit awareness of health promotion emerged from the data which illuminates students understandings of the term 'holism'. Here they were able to describe some of the broad socio-economic underpinnings that were largely absent from the definitions of health promotion. It would appear from the data that students do see the patient in the context of his or her environment, and are aware of socio-economic influences on health, and empowerment issues, but that they are not labelled 'health promotion'. For example, a student at the beginning of the course suggested holism was:

> *"Looking at the person as a whole. Psychological, physically and socially. Understanding that all these things are connected and affect a persons health/ill health."* [145141]

Whilst another student at the end of the common foundation programme suggested holism is:

> *"Total care, taking into account social background, family history, life style, diet etc. The actual care, "hands on". Health education in order to have a successful discharge."* [141333]

Students at time points C to F inclusive were asked about how difficult, or easy it is to put health education / health promotion into practice in the practice environment (Q 019). Implementing health education / health promotion in the practice setting was generally seen to be 'difficult' by over half of respondents at time points C to F. Interestingly a difference in responses between centres for this question was noted. Chi square tests were performed and data generated from question 019. Cohorts 1, 2, and 3 (from centre 1) found it significantly more difficult to put health education /promotion into practice than cohorts 5, 6, and 7 (centre 2) ($p<0.05$). This was further confirmed by a Mann-Whitney test between centres which demonstrated a significant difference between centres ($p<0.001$). The barriers to putting health education and health promotion into practice included patient reluctance and lack of knowledge. Facilitators included motivated patients and having sufficient resources available (see table 15 below).

Table 15: Q019 Difficulties/Facilitators in putting health education/promotion into practice?

Questionnaire:	C (18 months)		D (27 months)		E (End)		F (6 months post)	
Category	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*
Inhibiting Factors								
Patient reluctance/ lack of compliance	52	28%	90	35%	55	40%	37	55%
Lack of knowledge/status	31	17%	24	9%	4	3%	7	10%
Structural Constraints	28	15%	71	28%	26	19%	31	46%
Political/socio-economic influences	9	5%	31	12%	12	9%	1	1%
Staff act as barrier	5	3%	16	6%	9	6%	4	6%
Facilitating Factors								
Resources available	49	26%	35	14%	15	11%	22	33%
Communication/teaching skills	18	10%	41	16%	25	18%	11	16%
Motivated patients	17	9%	19	7%	19	14%	17	25%
Ward philosophy/positive staff	9	5%	30	12%	19	14%	13	19%
Knowledge	7	4%	21	8%	19	14%	18	27%
"Depends"	4	2%	3	1%	1	1%	0	0%
Good patient relations	3	2%	17	7%	17	12%	6	9%
Other	13	7%	13	5%	15	11%	5	7%
Total responses	245		411		236		172	
Total respondents	186		256		139		67	

Illuminating patient reluctance, a student twenty seven months into the course suggested:

> *"You can take a horse to the water but you cannot make it drink"* [271404]

Time was often considered to be a problem as a student in centre two commented:

> *"very little time to be able to give patients detailed programmes. Usually it is difficult to check on their personal understanding as nurses only see them on the ward there is no follow through of a health education programme to check that the patient has adequate understanding and support."* [261517]

Another reflected some of the other structural constraints such as staff shortages acting as a barrier:

> *"time is always a barrier and spending time talking to patients about issues is often frowned upon by other staff as there are 'more important' tasks to do such as bed making or washing."* [251405]

Other structural constraints mentioned ranged from a lack of time and materials to being unable to liaise with an appropriate member of the multi-disciplinary team such as a dietician. There appeared to be a marked increase in the importance placed upon structural constraints and their impact for an effective health promotion role as time progressed with a growing recognition of macro influences such as socio-economic status:

> *"getting time to teach patients; not being able to alter patients' social conditions so that health promotion becomes rather pointless - i.e. unemployment, low social*

> *circumstances. Still worth giving information however but not everyone can take choices over diet etc."* [261417]

As students progressed from the end of their CFP to post registered practice the implications of lack of time, materials and staff became crystallised. Their awareness of the economic side to health care appears to increase in proportion to their attempts to implement their ideas and ideals of care.

In summary, health promotion was in general poorly understood, although most felt there was a distinction between the two concepts of health promotion and education. Definitions of both focused upon a more individualistic and lifestyle approach. However the students did indeed illustrate an implicit grasp of the more complex issues surrounding health promotion, often expressed in the context of holism and holistic care.

Changing Perceptions of the Philosophy and Practice of Nursing

At the first point of contact with each student, they were asked to recall their thoughts of nursing upon commencement of the course (Q009). Whilst they all perceived nursing as a caring profession, an emphasis on practical and physical work and nursing the sick also predominated. A student who had recently commenced the course (A) commented:

> *"Nursing sick people back to health, I did not think health promotion and looking at the holistic approach would come into the training as much as it is."* [281101]

Whilst another also emphasised the illness orientation, at the expense of holism:

> *"I realised that nursing was more than just caring for people however, I was not particularly aware of factors such as culture and religion and how they would affect approaches to nursing clients. In many ways my attitude towards nursing was to concentrate on the 'ill' part of a person and not necessarily regard the person as a whole."* [281105]

Students were then asked at subsequent time points whether their initial view of nursing had changed in any way (Q 041). Over 70% subsequently felt that their view of nursing had changed and highlighted a more theoretical, broader perspective with an emphasis on health and health promotion (see table 16 below).

Table 16: Q041 Since beginning the Project 2000 course, has your initial idea of what nursing is about changed in any way?

Questionnaire:	B (9th months)		C (18th months)		D (27th months)	
Category	*n*	%	*n*	%	*n*	%
Broader perspective	52	28%	42	24%	66	27%
More theoretical	41	22%	41	23%	91	37%
More emphasis on health promotion	32	17%	21	12%	17	7%
Incr emphasis on accountability/high pressure	22	12%	14	8%	52	21%
No change	22	12%	24	14%	37	15%
Emphasis on management role/admin.	16	9%	24	14%	60	24%
Less patient orientated	16	9%	11	6%	42	17%
More research based	16	9%	15	9%	30	12%
Care is resource driven	11	6%	4	2%	47	19%
More patient orientated	9	5%	24	14%	18	7%
More cynical/less idealised	1	1%	7	4%	13	5%
Other	19	10%	24	14%	42	17%
Total responses	257		251		515	
Total respondents	185		175		249	

Asked to identify the causes of such changes (not included in table 16 above), theoretical input from the course was the predominant response from 35% of the sample nine months into the programme. Further on in the course at eighteen and twenty-seven months, 28% identified this factor as influential and 41% identified exposure to practice as an important influence. Nursing was also increasing seen to encompass the broader perspective of multi-disciplinary work in both hospitals and the community. Some students highlighted negative changes in their views of nursing which included care being resource driven, less patient orientated, with an emphasis on the administrative role of the nurse. Changes in the NHS were also perceived to have had an impact, as a nurse half way through the branch programme commented:

> *"Yes- when I first wanted to train, things were very different. On the positive side, nursing has moved towards holistic care and research based practice. Doctors are no longer Gods who "descend" on the ward and dish out orders. On the negative side, nurses are expected to think about financial issues, legal aspects, who does and doesn't have a fund holding GP etc. Staff shortages are phenomenal and we are sometimes managed by people who have never nursed and don't know anything about it."* [271463]

This was also seen to have had an impact on nursing in general with 'politics' and 'NHS reforms' being the most frequently cited response across all access points questioned Respondents were asked about general changes in nursing at time points B, C, D, and E (Q042). Over 80% of students felt that nursing in general was changing with the most commonly cited response being related to political NHS reforms (see table 17 below). As a student in centre one (D) commented:

> *"The movement towards a more market economy means that nursing is going to have much more emphasis on 'value for money' - not good news for patients. In a positive way though, nurses are changing things through research etc."* [111451]

Students also cited changes such as striving for professionalism and the more knowledgeable research aware practitioner facilitated by Project 2000. As one student put it:

> *"Yes - the introduction of Project 2000 has obviously been part of the change, however, increased emphasis on research and a knowledge base is raising the professional status of nurses. Also the introduction of community care, reduction in length of stay for patients in the acute hospital setting, and the introduction of trust status for hospitals is all contributing towards a changing role for nurses."* [271422]

Table 17: Q042 Do you think nursing in general is changing? If yes, what do you think has been the major cause of this change?

Questionnaire:	B (9 months)		C (18 months)		D (27 months)		E (End)	
Category	*n*	%	*n*	%	*n*	%	*n*	%
Political/NHS reform	90	41%	89	48%	136	55%	85	64%
More knowledgeable practitioner/P2K	62	28%	45	24%	90	36%	39	29%
Meeting demands of changing social trends	59	27%	23	13%	39	16%	12	9%
Greater research awareness	43	20%	37	20%	60	24%	36	27%
New philosophy of care	37	17%	19	10%	28	11%	15	11%
Striving for professionalism	35	16%	39	21%	67	27%	22	17%
Increased managerial role of qualified nurses	29	13%	27	15%	25	10%	20	15%
Advances in medicine/ technology	18	8%	3	2%	10	4%	3	2%
Other	4	2%	5	3%	12	5%	7	5%
No change	2	1%	18	10%	2	1%	10	8%
Total responses	379		305		469		242	
Total respondents	218		184		249		133	

However, despite the Project 2000 programme and the new quest for a questioning, assertive nurse, some suggested that although nurses were not the 'hand maidens' they once were, nurses remained *'hidebound by tradition and what the doctor says'* [141306]. As a student half way through the course reflected:

> *"Even the new system P2000 is having to fit into the existing routines/environment....it should prevent many conditions. Nurses are not strong enough politically."* [141315]

As discussed previously the largest change in perceptions of nursing following rostered service was the realisation that care is resource driven. The following quotes represent the strength of feeling experienced by students in both centres when their philosophy of nursing meets financial constraints:

> *" I think my view of nursing has changed because I have seen so many short-staffed wards where patients have been continually complaining about the care they are receiving. Patients are having to 'wait' longer when they call, as staff are just too busy. Morale is extremely low within nursing, making a fulfilling job*

> *seem sometimes like low-paid slavery. A grateful patient makes the job so worthwhile."* [111515]
>
> *"Money seems to have overtaken the interest of the individual in nursing although the educators are still crying 'holism'. The new structure of the NHS seems to contradict some basic nursing concepts."* [261507]

Section Summary

It would appear from the data presented above that students' views on the nature of nursing did change as the course progressed. Students entering the course predominantly believed nursing to be about caring for the sick, with a physical and practical emphasis. Students' opinions subsequently appear to have been moulded at least to some extent by exposure to the Project 2000 course, with concepts such as holism and health promotion entering their understandings. Over time nursing was perceived to be much broader in focus with a greater theoretical emphasis than had first been supposed. Basic nursing care was also seen as most important, with the patient placed firmly at the centre of health care delivery. Effective nursing care was seen as a move away from the reductionist medical model. Nursing in general was perceived by students to be changing, and Project 2000 was part of this change. The NHS reforms were also cited as having an important influence on nursing. Students suggested resources were tight and care was often resource driven, which at times hindered the application of some basic nursing concepts. It would appear that students have been taught that there were differences between the two concepts of health education and health promotion, but were not clear about the different meanings. Many respondents appear to have adopted a lifestyle orientated approach to both concepts, ignoring the broader socio-economic and policy level implications of the term health promotion. Students understanding of this was variable with some demonstrating awareness of the broader determinants of health, although these were more frequently alluded to in connection with the concept of holism rather than in connection with health promotion. Difficulties were encountered in attempting to put health education and health promotion into practice, and these included patient reluctance and compliance, limited staff support and lack of time. A caring patient orientated approach to nursing care was seen as essential and communication and inter-personal skills were valued by students. A sound theoretical base assumed importance as students progressed through the course. At the end of the course students keen to act as patient advocates possessed a thirst for change and valued their interpersonal skills. As the course progressed, professional skills were increasingly seen as important, together with research based practice.

3. 3. STUDENTS PERCEPTIONS OF THE COURSE AS A PREPARATION FOR PROFESSIONAL PRACTICE AND SOCIALISATION INTO THE PROFESSIONAL ROLE

Several questions throughout the questionnaire invited students to reflect on their Project 2000 course, both in terms of the subject content and the teaching and its relevance as a preparation for practice.

Strengths and Weaknesses as a Preparation for Practice

Students at the end of the common foundation programme, and those at the end of the course were asked to consider the advantages and disadvantages of the Project 2000 programme (Q 056). Qualified Project 2000 nurses were similarly asked to consider the strengths and weaknesses of the course (Q 098).

The major general advantage of the Project 2000 course was seen to be its broad theoretical base and the academic credit in the form of a diploma which came upon completion of the programme. A student at the end of the course suggested:

> *"It has made me a thinking nurse."* [111580]

The questioning and analytic approach fostered by the course was valued, together with the emphasis on supernumerary status with students perceiving being a learner rather than a worker, a distinct advantage. The perceived main disadvantages were the lack of practical skills, stigma from others and the financial pressures which were imposed through students receiving bursaries. (See table 18 below)

Table 18: Q056 Advantages/disadvantages of doing a Project 2000 course?

Questionnaire:	C (18 months)		E (End)	
Category	*n*	%	*n*	%
Advantages				
Broad theoretical base & education	104	58%	56	44%
Academic base/credit	67	37%	48	38%
Learner not a worker	45	25%	36	28%
Questioning/analytic	31	17%	29	23%
Good preparation/way forward	24	13%	25	20%
Prepared for hospital and community	21	12%	12	9%
Patient focused	9	5%	11	9%
Disadvantages				
Lack practical skills/experience	107	60%	40	31%
Attitude of others	47	26%	37	29%
Financial	36	20%	36	28%
Course organisation	24	13%	29	23%
Too much theory	19	11%	4	3%
Poor support from nurse teachers	0	0%	2	2%
Others disadvantages	16	9%	19	15%
Total responses	550		384	
Total respondents	179		128	

When asked to assess the advantages and disadvantages of supernumerary status (Q037) the comments were remarkably consistent across time with those from the end of CFP onwards feeling its greatest advantage was to facilitate learning, which in turn nurtured a feeling of confidence in practice as indicated in table 19 below.

Table 19: Q037 Advantages and disadvantages of "supernumerary status".

Questionnaire:	C (18 months)		D (27 months)		E (End)	
Category	*n*	%	*n*	%	*n*	%
Advantages						
Nurtures confidence in practice (time to get it right)	135	70%	108	42%	55	39%
Facilitates learning	139	72%	208	80%	118	84%
Facilitates patient contact/relationship	14	7%	17	7%	16	11%
No advantages	0	0%	10	4%	1	1%
Disadvantages						
Not part of the team	86	45%	123	47%	70	50%
Inhibits practical skill acquisition	39	20%	84	32%	46	33%
Staffs misconception/inappropriate expectations	35	18%	86	33%	52	37%
Service demands take precedence over learning	26	14%	25	10%	21	15%
Unpaid (unsociable hours)	19	10%	23	9%	6	4%
No disadvantages	2	1%	8	3%	1	%
Total responses	495		692		386	
Total respondents	192		259		141	

However the advantages of supernumerary status were counterbalanced by perceptions of not feeling part of the team, which in turn was felt to inhibit practical skill acquisition. The other major disadvantage was the misconception of supernumerary status and at times the inappropriate expectations of staff. Some students felt they were given less recognition than health care assistants, seen as either an extra pair of hands, lazy or merely a hindrance. Their acquisition of practical skills was seen to be inhibited by the lack of continuity of care provision and limited responsibility given for practice. A student at the end of the CFP reflected:

> *"Advantages: able to learn, not as much pressure, able to see multi-disciplinary team work, learn things properly as have time to do things slowly. Disadvantages: Not seen as part of the team, not allowed to do some procedures"* [135243]

Students perceptions of rostered service (Q 039) appeared to mirror the answers given in response to the assessment of supernumerary status. Most agreed that the major advantage of rostered service was feeling part of the team, followed by the increased respect and responsibility bestowed. As table 20 illustrates the major disadvantage was the perceived reduction in learning opportunities that followed and their perceived role as 'cheap labour'. A student at the end of the course commented:

> *"Advantages: feel more like one of the team - feel like you are making a contribution (with) more time in (an) area to gain clinical experience. Disadvantages: Can feel 'used' - poor off-duty (and) heavy clinical and academic work commitments at the same time"* [121514]

Table 20: Q039 Advantages and disadvantages of rostered service

Questionnaire:	E (End)	
Category	*n*	%
Advantages		
Part of the team	105	74%
Given responsibility/respect/taken seriously	53	38%
Facilitates learning	41	29%
Preparation for qualification	27	19%
Increased continuity/get to know patient/family better	22	16%
Other advantages	5	4%
Disadvantages		
Used as cheap labour/financial	77	55%
Reduced learning opportunities/worker not learner	72	51%
Hard work/ high pressure/stress	19	13%
Staff expectations/negative attitude	13	9%
Other disadvantages	7	5%
Total responses)	441	

The students were asked to what extent their Project 2000 course had prepared them for practice (Q 054). As can be seen from table 21 the overwhelmingly consistent response was, that it had prepared them, and had done so well. From the end of the CFP onwards over two thirds of the students continued to share this perception which was sustained well into their first year of post registered practice. However, up to one quarter of students and qualified nurses suggested that they felt the course had not prepared them. One of the most consistently identified issues associated with this was poor practical skills preparation (see below).

Table 21: Q054 To what extent has Project 2000 prepared you to practice?

Questionnaire:	C (18 months)		D (27 months)		E (End)		F (6 mths post)	
Category	*n*	%	*n*	%	*n*	%	*n*	%
Prepared	134	74%	200	78%	121	88%	53	75%
Not prepared	47	26%	54	22%	17	12%	18	25%
Total	181	100%	254	100%	138	100%	71	100%

* Chi Square tests were performed on the D questionnaire and demographic data revealing a significant test result (p<0.05) by cohort and age(see appendix 25 for chi-square and mann-Whitney tables).
** Sign test E to F showed significant (p<0.01) difference between responses
NB: 7 cases at F were unable to answer the question.

Table 22 below presents the main categories of comments from students on the course associated with their preparation for practice (Q054).

Table 22: Q054 Preparation for practice: Comments

Questionnaire:	C (18 months)		D (27 months)		E (End)	
Category	*n*	%	*n*	%	*n*	%
Lack of practical skills/prep/experience	44	48%	80	41%	17	25%
Academic/research/broader base	17	18%	62	32%	16	23%
Poor course organisation/ unbalanced	11	12%	54	28%	24	35%
Lifelong learner	8	9%	35	18%	17	25%
Prepared to challenge	4	4%	28	14%	7	10%
Other	19	21%	47	24%	18	26%
Total responses	103		306		99	
Total respondents	92		194		69	

The biggest criticisms were that the courses were often poorly organised and were perceived to be lacking in practical skills. A student responded in questionnaire D that:

> *"I will become the thinking doer who doesn't fully know what to do."* [112463].

However, this perceived lack of skills decreased with the progression of the course. Their belief that there was always more to learn as a "lifelong learner" increased as the course progressed. The following comment from a student at the end of the course reflects this general feeling:

> *"I think it makes you value that no matter how much you've learnt so far there is an awful lot left to discover. Nursing is continually changing and expanding."* [111562]

As indicated in table 21 there were however some differences between centres in the extent to which students felt prepared for practice. The cohort differences appeared to reveal centre differences which were further explored by use of the Mann-Whitney test. Differences between the centres proved significant (p<0.001) confirming the chi-square cohort test. Students appear to perceive themselves less well prepared for practice in centre 2 than in centre 1. The sign test also revealed that the qualified diplomates perceived themselves as less well prepared than students at the end of the course (see table 21 above). It may be suggested that the diplomates gain a more realistic expectation of what preparedness really means and no longer expect it to be the once and for all totally comprehensive preparation. A student 27 months into the course summed up the feelings of many:

> *"At the beginning of training I was very doubtful but now I feel P2000 prepares you well for a general nurse. It prepares you to be open minded and ready for any challenge that may occur."* [271413]

Their assessments reflect the perception that the course had provided sound academic underpinnings and a broad research knowledge base. See table 22 above. The reduction in the percentage of those who believed the course had prepared them between the end of the course and 6 months post qualification, may indicate that once in practice the diplomates had a much better idea of their preparation for practice. The expectations of others and limited support in the practice environment may also have influenced this change in perception.

Preparation for Practice: Key Influences

Students were also asked to comment on more specific aspects of the course, including subjects of most help, teaching qualities, and subjects covered in too much depth, or insufficient depth. When the students were asked to describe the qualities of a good teacher (Q 023), the universally accepted need was for their role to be supportive and focused upon students needs. (See table 23 below)

Table 23: Q023 Five qualities of a "good" tutor

Questionnaire:	A (Start)		B (9 months)		C (18 Months)		D (27 months)		E (End)	
Category	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
Student orientated/support	144	92%	227	97%	190	93%	253	97%	134	95%
Teaching skills	125	80%	167	71%	130	64%	159	61%	83	59%
Personal qualities	103	66%	97	41%	98	48%	121	46%	57	40%
Knowledge*	40	25%	71	30%	98	48%	96	37%	68	48%
Open to question	24	15%	0	0%	0	0%	32	12%	20	14%
Professional qualities	17	11%	29	12%	28	14%	39	15%	25	18%
Clinical credibility*	0	0%	31	13%	33	16%	67	26%	29	21%
Other	0	0%	0	0%	0	0%	3	1%	6	4%
Total responses	453		622		577		770		422	
Total respondents	157		234		204		262		141	

* The test of differences between proportions revealed a significant ($p<0.01$) difference between the responses at A and E.

The importance of teachers being student orientated and supportive was followed by their teaching skills and personal qualities. Personal qualities seen to be required included a sense of humour, patience, enthusiasm and honesty. Students also valued professional qualities such as being organised and punctual, together with clinical credibility and teachers' knowledge. The latter appears to become significantly more important to students as the course progresses (see table 23 above).

The subjects students perceived to be of greatest help to them in the practice area, across the board were interpersonal skills, life sciences and practical skills. (Q 024). Life sciences and practical skills appear to be of greatest value at the end of CFP and there was a steady significant increase in the value placed upon research. Conversely the need to acquire practical skills and procedural knowledge reduces as the course progresses (See table 24 below).

Table 24: Q024 Subjects of greatest help in the practice area

Questionnaire:	B (9 months)		C (18 months)		D (27 months)		E (End)		F (6 months post)	
Category	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
Practical skills	108	48%	128	65%	65	25%	38	28%	20	26%
Life Science	97	43%	103	52%	108	42%	54	39%	25	33%
Inter-personal skills	74	33%	43	22%	95	37%	51	37%	32	42%
Psychology	60	27%	27	14%	62	24%	47	34%	20	26%
Sociology	43	19%	24	12%	57	22%	38	28%	16	21%
Branch knowledge	24	11%	3	2%	12	5%	7	5%	1	1%
Nursing theory	22	10%	30	15%	29	11%	22	16%	7	9%
Ill health	21	9%	11	6%	43	17%	24	18%	10	13%
Drugs	14	6%	7	4%	14	5%	6	4%	6	8%
Health education/promotion	13	6%	10	5%	6	2%	7	5%	2	3%
Research*	9	4%	11	6%	33	13%	22	16%	19	25%
Nursing ethics	7	3%	8	4%	10	4%	1	1%	5	7%
Personal development	1	0%	2	1%	4	2%	2	1%	1	1%
Management	0	0%	3	2%	12	5%	8	6%	8	11%
All	6	3%	2	1%	10	4%	6	4%	4	5%
Other/none	7	3%	3	2%	12	5%	11	8%	14	18%
Total responses (A)	506		415		573		343		190	
Total respondents (P)	223		198		258		137		76	

* Using the test of differences between proportions to compare the proportion of answers in this category at point B (9 months) and point F (6 months post) they were found to be significant ($p< 0.001$)

Students were also asked if there were any subject areas they would like to have covered in greater depth (Q025). As seen from table 25 life sciences and practical skills continue in their perceived importance across the course and between the centres, although the importance of clinical procedures significantly decreases as the course progresses.

Table 25: Q025 Subjects that should be covered in greater depth

Questionnaire:	B (9 months)		C (18 months)		D (27 months)		E (End)		F (6 months post)	
Category	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
Clinical procedures*	101	47%	77	41%	73	29%	24	19%	23	31%
Life sciences	69	32%	82	44%	116	46%	79	61%	40	54%
Branch programme knowledge	29	14%	15	8%	12	5%	10	8%	3	4%
Pharmacology	28	13%	21	11%	40	16%	14	11%	9	12%
Psychology	21	10%	18	10%	14	6%	14	11%	8	11%
Inter-personal skills	16	7%	6	3%	14	6%	19	15%	8	11%
Sociology	16	7%	5	3%	18	7%	13	10%	4	5%
None	11	5%	4	2%	16	6%	0	0%	0	0%
Ill health	10	5%	13	7%	56	22%	22	17%	11	15%
Nursing theory	7	3%	11	6%	3	1%	4	3%	0	0%
Nursing ethics	3	1%	6	3%	5	2%	6	5%	6	8%
Research	3	1%	6	3%	9	4%	5	4%	1	1%
Health education/promotion	2	1%	1	1%	1	0%	1	1%	0	0%
Management	2	1%	2	1%	15	6%	11	9%	8	11%
Personal development	2	1%	2	1%	0	0%	0	0%	0	0%
All	0	0%	2	1%	1	0%	0	0%	0	0%
Other	6	3%	4	2%	23	9%	20	16%	4	5%
Total responses	326		275		416		242		125	
Total respondents	214		186		252		129		74	

* Using the test of differences between proportions to compare the proportion of answers in this category at point B (9 months) and point E (end) they were found to be significant ($p < 0.001$)

Students were also requested to consider whether any subjects in the curriculum had been covered in too much depth (Q 026). Responses included research (8 -19% of responses B to F) , psychology (10 -18% of responses across B to F) and sociology (14-19% of responses B to F). Research was often judged to be badly taught, with little liaison between different lecturers, particularly in centre 2 producing a course which never got beyond defining what research was. Psychology in centre 1 was often criticised for not being related to nursing although acknowledged as an interesting subject in its own right. Professional, legal and ethical studies were particularly unpopular in centre one (8-32% B to F) for the most part due to poor teaching and the wider context of nursing (history of NHS) was also fairly unpopular.

Professional Socialisation

Several questions were included in the questionnaires to generate data to inform understandings the process of socialisation into the professional role (aim 5).

Role Models and the Influence of Others

Students were asked which people had had the greatest influence upon their key understanding of nursing (Q 031). Twelve categories were identified for students to choose from and respondents were also free to complete an "other" category. They were asked to rank their responses with the most influential person ranked first. It is these top ranked responses that are presented here. (See appendix 26 for the second ranked responses). It would appear from the data presented in table 26 below, that perhaps unsurprisingly it is those with whom the student has most contact at given points on the course, that have the greatest influence.

Table 26: Q031 People with greatest influence upon understanding of nursing

Questionnaire:	A (Start)		B (9 months)		C (18 months)		D (27 months)		E (End)	
Category	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
Teachers/lecturers	105	73%	80	39%	45	24%	70	27%	27%	20%
Other students	9	6%	11	6%	5	3%	4	2%	5%	4%
Personal teacher	5	3%	2	1%	7	4%	23	9%	7%	5%
Ward sister	5	3%	1	0%	5	3%	7	3%	6%	4%
Staff nurses	4	3%	22	11%	33	18%	48	18%	37%	27%
Clients	3	3%	7	3%	3	2%	15	6%	12%	9%
Friends/family	3	3%	3	1%	1	0%	0	0%	0%	0%
Community staff	3	3%	38	18%	7	4%	7	3%	4%	3%
Enrolled nurses	2	1%	1	0%	5	3%	2	1%	0%	0%
Health care assistants	2	1%	0	0%	2	1%	2	1%	0%	0%
Mentor	2	1%	41	21%	71	38%	80	30%	39%	28%
Link teacher	0	0%	0	0%	1	0%	1	0%	0%	0%
Medical staff	0	0%	1	0%	0	0%	1	0%	0%	0%
Nurse manager	0	0%	0	0%	0	0%	0	0%	0%	0%
Previous experience	0	0%	1	0%	0	0%	0	0%	0%	0%
Myself	0	0%	1	0%	0	0%	0	0%	0%	0%
School nurse	0	0%	1	0%	0	0%	0	0%	0%	0%
Total respondents	144		210		186		261		137	

NB: Where n=1 < .005 it has been rounded to 0%

At points A and B the teachers and to some extent community staff emerge as most influential, whilst at point C, mentors and staff nurses begin to take precedence. Teachers do maintain some influence throughout the course, but towards the end, mentors and staff nurses hold sway. Diplomates at time point F, were also asked what or who had been the greatest influence upon their practice as a nurse (Q 099). The most frequently cited responses were mentors/ preceptors (22%), clinical colleagues in general (23%), followed by teachers (13%) and peers/friends(11%). One newly qualified nurse identified her mentors because:

> *"You aim to be like them, to have such ambition, to have a patient saying "Thank you nurse, I feel great" to you, it's what it's all about - patient satisfaction"* [111641]

Another newly qualified nurse identified nurse teachers and suggested this was because they were:

> *"Full of encouragement, able to relate their past experiences to yours, help you see past any problems - they can truly see the end result of you reaching a staff nurse even if you can't the simple fact of them believing in you - this held more ground than families well meaning support at times"* [261606]

In addition to these questions students at nine and eighteen months into the course, together with newly qualified diplomates were asked if they had encountered a good nursing role model (Q 032). The majority at each access point responded 'yes' (63% at B, 84% at C, and 86% at F). As shown in table 27 when asked to list the qualities of the role models, caring, inter-personal skills, and professional skills were all valued.

Table 27: Q032 What qualities should a good nursing role model have?

Questionnaire:	B (9 months)		C (18 months)		F (6 months post)	
Category	*n*	%	*n*	%	*n*	%
Inter-personal skills	76	53%	100	58%	39	53%
Caring	73	51%	47	27%	22	30%
Professional skills	68	47%	92	54%	51	69%
Nursing knowledge	54	38%	81	47%	33	45%
Patient orientation	50	35%	73	43%	20	27%
Personal qualities	47	33%	61	36%	41	55%
Potential for change	19	13%	22	13%	16	22%
Non-judgmental	16	11%	8	5%	3	4%
Team orientation	7	5%	11	6%	17	23%
Organisation/management skills	2	1%	2	1%	16	22%
Total responses	412		497		258	
Total respondents	144		171		74	

Professional skills appear to become more important as the course progresses, whilst caring, and inter-personal skills are less popular. Professional skills include being fair to colleagues and remaining calm and in control, together with good practical skills and being professional, reliable etc. Organisation and management skills together with the 'potential for change' also increased by six months post-qualification. A staff nurse who had been qualified six months from centre one suggested the qualities of a good role model included:

> *" A high degree of motivation, an excellent knowledge base. Wanting to always improve on (their) level of knowledge and nursing practice. Research based practitioner adaptable to change".* [121646]

Students Perceptions of themselves as Professional Nurses

Students were asked whether they thought of themselves as a nurse (Q 043) across all time points. As may be expected, the strength of this perception increased as the course progressed. At the beginning of the course only 29% saw themselves as a nurse. This rose to 39% at 9 months, 61% at 18 months, 83% at 27 months and 95% by the end of the course. The largest increases appear between B and C, and between C and D. At the end of the CFP (C) they will have 'hit practice', and by twenty seven months into the course (D) they will have commenced rostered service. It did appear that 'practical' / 'clinical' work equated with 'nursing' for many students. There was particular emphasis on this for those at the beginning of the course, who were required to wait some months before 'getting the uniform on'. As a student who had just commenced the course commented:

> *"No - We haven't done any practical training yet and I feel more like an ordinary student at college than a student nurse, as so far I've only been at college. You tend to lose sight a little of what you're doing here and what you want to do at the end of it all."* [281141]

Some in the numerically smaller branch programmes (mental health, learning disabilities and child) appeared to experience difficulties with the title 'nurse', or at least some of their colleagues had difficulty, as a student nine months into the course suggested:

> *"Nurse" is seen by the public as Florence Nightingale - have already been told that I won't be a "proper" nurse with RNMH."* [273210]

The 'lay' image of nursing persisted for many, and was at odds with their new preparation, such that a student twenty seven months into the course on the adult branch programme did not perceive herself as a nurse because:

> *"Project 2000 nurses are health care practitioners, health educators/promoters. Nursing implies to me that you just get the patients up, feed them and wash them."* [111438]

Another however, had no difficulty reconciling the two, answering 'yes' because:

> *"Yes - I give holistic care to the best of my ability based on research - based knowledge. I try to meet the patients' needs."* [271423]

Perceived differences between Project 2000 and Traditionally Trained Nurses?

Students were asked to identify whether they saw themselves as 'different' to traditionally trained nurses?" (Q 044). Students at the beginning of the course appear to perceive significantly greater differences than those at the end of the course and newly qualified nurses (see table 28 below).

Table 28: Q044 As a Project 2000 nurse to what extent, if at all, do you see yourself as 'different' from traditionally trained nurses?

Questionnaire:	A (Start)		B (9 months)		C (18 months)		D* (27 months)		E (End)		F* (6 mths post)	
Category	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
Different	110	71%	171	74%	141	73%	158	61%	84	60%	34	45%
Not different	45	29%	59	26%	52	27%	100	39%	55	40%	42	55%
Total	155	100%	230	100%	193	100%	258	100%	139	100%	76	100%

* Kolmogorov-Smirnov tests indicates a significant decrease in the view that Project 2000 nurses are different from traditionally trained nurses, between A (start) and F (6 months post) ($p<0.001$), and between B (9 months) and D (27 months) ($p< 0.05$).

The most commonly cited differences include Project 2000 nurses having more theoretical and academic input, a broader knowledge base and less practical experience (see table 29 below). As a student nine months into the course joked:

> *"They know how to do it, we know how to talk about it!!"* [281232]

Another student at the end of the course suggested:

> *"I think P2000 nurses tend to think more before they do. They are less task orientated and seem to outshine traditionally trained nurses in communication skills."* [111515]

These perceptions of themselves as more academic, with greater theoretical knowledge and less practical experience may be indicative of the socialisation process they have undergone. Project 2000 students are further removed from service delivery and the apprenticeship model, and arguably much more influenced and socialised by the college and teaching staff than their predecessors.

Table 29: Q044 Difference between Project 2000 and traditionally trained nurses

Questionnaire:	A (Start)		B (9 months)		C (18 months)		D (27 months)		E (end)		F (6 mths post)	
Category	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
More theory/academic input	88	58%	105	48%	87	47%	102	40%	45	33%	23	31%
Less practical experience	46	30%	76	35%	66	35%	72	28%	30	22%	17	23%
Thirst for change*	29	19%	37	17%	42	23%	60	24%	45	33%	28	37%
The same**	23	15%	34	16%	30	16%	68	27%	40	29%	20	27%
Broader knowledge base	21	14%	19	9%	21	11%	39	15%	22	16%	7	9%
Different approach to patient care	8	5%	6	3%	4	2%	16	6%	12	9%	11	15%
Health Education/prom emphasis	7	5%	7	3%	3	2%	5	2%	2	1%	2	3%
Contribute less to service	5	3%	15	7%	3	2%	10	4%	6	4%	1	1%
More management skills	4	3%	5	2%	4	2%	6	2%	4	3%	1	1%
Seen as different/stigmatised	4	3%	4	2%	8	4%	21	8%	10	7%	2	3%
Other	12	8%	17	8%	11	6%	41	16%	20	15%	11	15%
Total responses	247		325		279		440		236		123	
Total respondents	152		219		186		255		136		75	

**Using the test of differences between proportions to compare the proportion of answers in this category at point A (start) and point F (6 months post) they were found to be significantly different (p< 0.01].

*Using the test of differences between proportions to compare the proportion of answers in this category at point A (start) and point F (6 months post) they were found to be significantly different (p< 0.05].

As shown in table 29 changes in perceptions over time can be seen. Particularly striking is the significant increase in those suggesting that Project 2000 nurses possess a "thirst for change" less obvious in their "traditional" colleagues. Eventually the importance of gaining practical experience appears to diminish as the course progresses, whilst the view that Project 2000 nurses have a different approach to care assumes a higher profile.

However it is important to note that as the course progressed the students were significantly less likely to see themselves as different. For the newly qualified nurses this may reflect overcoming concerns about their initial skills deficit:

> *"Although initially on qualifying I may have felt there was a large gap I now feel I have quickly adapted to practice and feel that my practical skills are as good as anyone else's".* [121628]

Another suggested:

> *"I have found this to have no bearing on being qualified at all. The ward focuses on new techniques, dressings, etc., all of the time and so the learning process from a practical point of view is ongoing, rather than finite. I think the suggestion that P2000 nurses are disadvantaged practically, assumes that all practical skills can be acquired in 3 years - impossible!"* [111608]

There was also a feeling that they were all nurses doing the same job. There was also some reluctance to compare themselves with "traditional" nurses who increasingly assume the role of mentors and colleagues as the course progresses. A staff nurse six months post qualification suggested:

> *"I have only recently told other members of staff that I have done the P2000 course and am pleased to say they had no idea, other than I seemed to know a lot more about why things were done, how drugs worked etc. than the other new staff nurse."* [251606]

And another appeared to want to continue the 'fitting in' process:

> *"The majority of nurses are here for the same thing, to care about/for their patients. If we are different when first qualifying, it shouldn't take long to blend in for most nurses."* [111614]

Students' Perceptions of themselves as a Worker or a Learner

Implicit in the above examples is the question of whether the course is socialising the student into the role of worker, learner, or both. Students were asked to evaluate whether they were seen by qualified nurses as a worker or a learner (Q036). See table 30 below:

Table 30: Q036 Extent to which qualified nurses assess you as a worker/learner

Questionnaire:	C (18 months)		D (27 months)		E (end)	
Category	*n*	%	*n*	%	*n*	%
Worker	73	42%	124	54%	79	60%
Learner	101	58%	104	46%	52	40%
Total	174	100%	228	100%	131	100%

•Chi-square tests demonstrated significant differences by qualification (p<0.05), by cohort (p<0.05), and by branch (p<0.001).(See appendix 27 for Chi-square tables).

The increase of worker status appears to coincide with a more active clinical role within rostered service, as a student 27 months into the course reflected:

> *"Being rostered staff now, learning opportunities on the ward are becoming more difficult. Instead of participating in a drugs round now I find myself doing other tasks on the ward, e.g. dinners, and teas."* [131411]

As a student at the end of the course suggested:

> *"As you go further through your training you seem to develop from a learner to a worker."* [111580]

There appeared to be some concern that traditional ward staff did not fully understand the concept of supernumerary status. A student at the end of CFP commented:

> *"Generally people treat you more as a learner. The only way to learn in my opinion is to work. Some people seem to see us as more of a worker, e.g. I was told to give out the lunches one day while my mentor and an enrolled nurse gave out the drugs - I know which I would have found more beneficial. We often get the comment "oh but the 'student' doesn't count"', which can be a bit off-putting. I find I tend to learn more when its busier because you've just got to get on with it."* [141336]

The chi square test results (See table 30) appear to suggest that those students who posses higher education qualifications were more likely to perceive themselves as learners. Similarly those undertaking the mental health branch programme were more likely to perceive themselves as learners than their adult branch colleagues. Cohorts 1, 2, and 3, (centre 1) were more likely to perceive themselves as learners than those in centre 2 (cohorts 5, 6, and 7). This was further tested with a Mann-Whitney test which revealed a significant difference (p<0.05) between centres. (See appendix 27 for chi-square and Mann Whitney tables).

"Fitting In "- The Issue of the Nurses Role within the Multi- Disciplinary Team

Respondents were asked to identify the specific contribution that nurses make to the multi-disciplinary team (Q052). As can be seen from table 31 'giving direct patient care' was felt to be the major role at B and C, but at D this had reduced significantly.

Table 31: Q052 Nurses contribution to multi-disciplinary team

Questionnaire:	B (9 months)		C (18 months)		D (27 months)	
Category	*n*	%	*n*	%	*n*	%
Gives direct patient care*	116	61%	108	66%	59	25%
Liaison/advice	41	21%	36	22%	90	38%
Central/pivotal	39	20%	39	24%	53	23%
Patient/family orientated (holistic)	27	14%	27	16%	30	13%
Most informed about client	10	5%	19	12%	68	29%
Teamwork	7	4%	9	5%	21	9%
24 hour contact*	4	2%	1	1%	55	24%
Limited extent/restricted	2	1%	5	3%	8	3%
Other	4	2%	7	4%	4	2%
Don't know	6	3%	0	0%	0	0%
Total responses	258		251		388	
Total respondents	191		164		234	

* Using the test of differences between proportions to compare the proportion of answers in these categories at point B (9 months) and point D (27 months) they were found to be significantly different ($p< 0.001$).

By 27 months liaison/advice had taken over as the most frequently cited contribution and the category related to being the ' most informed about the patient' was also more frequently identified. This may reflect further socialisation into the staff nurse role through rostered service that the students at D had undergone. Qualified diplomates were asked a similar question about the nurses contribution to the multi-disciplinary team (Q 097). The fact that nurses have '24 hour contact' was identified as a major factor along with the holistic approach embedded in nursing (see section 4.3. for more detail). These perceptions differ striking from those of the students who focused on the nurses role in giving direct patient care. This change in perceptions of the nurses role within the multi-disciplinary team could be associated with the socialisation into that role. The increase in night duty undertaken by qualified nurses may help explain the broader understanding of the role represented in the further rise in the responses in the category '24 hour contact'. Similarly, increased knowledge of the role of the staff nurse within the multi-disciplinary team may have facilitated the awareness that it is the nurse who spends more time with the patient than anyone, can act as patient advocate, and has a more holistic focus than multi-diciplinary team colleagues. A diplomate in centre one reflected:

> *"Nurses spend infinitely more time with the clients than any other profession - we have usually better relationships - more intimate knowledge and a greater level of trust."* [112674]

Another in centre two suggested:

> *"An in depth understanding of the patient and therefore how external forces e.g. unemployment, problems socially are having an effect on the health or motivation of patient to become well. Also knowing the patient's relatives well enough to know that the patient has had enough and would prefer a palliative rather then active approach to care."* [261617]

Being prepared to stand up for patients and to be an advocate was also seen by some to be a accepted role for nurses within the multi-disciplinary team. Challenging medical hegemony is indeed difficult, although perhaps better tolerated than challenging and confronting nursing colleagues and peers. When asked the extent to which they had to compromise their principles of nursing in order to fit in and be accepted by the nursing team members (Q 033) it would appear that students felt the need to compromise less as the course progressed. See table 32 below.

Table 32: Q033 Extent to which the student feels the need to compromise to "fit in"

Questionnaire:	C (18 months)		D (27 months)		E * (End)		F (6 mths post)	
Category	*n*	%	*n*	%	*n*	%	*n*	%
Compromise	103	53%	110	44%	50	35%	24	32%
Do not compromise	92	47%	142	56%	92	65%	51	68%
Total	195	100%	252	100%	142	100%	75	100%

* Kolmogorov-Smirnov test indicates a significant decrease in the need to compromise between point C (18 months) and the end of the course (E)($p<0.05$).

Whether students really feel the need to compromise less as the course progresses, remains open to question. Perhaps by the end of the course the students had already been socialised into more traditional ways of nursing. The questionnaire data suggest that students at C D and E felt a strong desire to 'fit in to survive'. This desire to be part of the team was linked with the understandable desire of many students to be popular and gain good ward assessments. A student at the end of the CFP reflected this:

> *"To keep the peace, as you are a student and general dogsbody or seem that way - you have to compromise to get along. Or you are treated badly and excluded a great deal."* [281117]

A student 27 months into the course commented:

> *"Sometimes you are seen as rocking the boat, and can begin to feel left out, so you try to accommodate in order to gain acceptance."* [121419]

Others however, were keen to remain true to their principles and uncompromisingly to put the patient above all else. Another student commented:

> *"Principles that I strongly believe in I will not alter just to be accepted by a nursing team and I speak out and say why although not in a confrontational manner. It is nice to be popular with nursing staff but at the end of the day patients come first."* [111426]

Whilst another concurred:

> *"I'm there to meet the needs of the patients not the needs of the staff"* [121534].

In contrast data from the qualified diplomates suggest that 'fitting in ' was no longer a priority, but that staff were generally open and receptive. See table 33 below.

Table 33: Q033 Compromise necessary to "fit in": Comments?

Questionnaire:	C (18 months)		D (27 months)		E (End)		F (6 months post)	
Category	*n*	%	*n*	%	*n*	%	*n*	%
Fit in to survive	30	19%	54	27%	24	29%	6	10%
Need to be flexible	25	16%	41	21%	22	27%	3	5%
Neg. staff/ resistance to new ideas	17	11%	52	26%	11	13%	3	5%
Stud. status reluctant to challenge	17	11%	31	16%	7	8%	3	5%
Staff open and receptive*	12	8%	24	12%	8	10%	14	23%
Patient remains priority	9	6%	42	21%	16	19%	10	17%
Structural constraints	8	5%	9	5%	1	1%	7	12%
Confidence to challenge/share ideas	1	1%	37	19%	16	19%	11	18%
Depends	3	2%	16	8%	13	16%	0	0%
Other	5	3%	4	2%	2	2%	3	5%
Total responses	127		310		120		60	
Total respondents	159		197		83		60	

* Using the test of differences between proportions to compare the proportion of answers in this category at point C (18 months) and point F (6 months post) it was found to be significantly different ($p< 0.001$).

This reduction in the need to "fit in" may reflect qualifiers greater choice of the practice environments in which they are able to work. A staff nurse commented:

> *"I am an independent practitioner. I can with diplomacy practice as I like."* [121630].

Another however had a more pragmatic approach:

> *" In order to make life easy it is often the case of making it look like you are compromising your nursing practice when in fact you aren't. 'Ward politics!'"* [111634]

Future Career Plans

When asked to consider their future career plans (Q 011) at all time points students appeared to reflect the issues pertinent at particular access points (see table 34). For example, students at A, B and C are keen to be based in the community. At this stage this is where they will have experienced the majority of their practical work. This has diminished by the end of the course (E) when the more pressing issue of 'get a job' has surfaced.

Table 34: Q011 Future career plans

Questionnaire:	**A (Start)**		**B (9 months)**		**C (18 months)**		**D (27 months)**		**E (End)**		**F (2 Yrs post)**		**F (6 Yrs post)**	
Category	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
To specialise	41	26%	40	17%	18	9%	45	17%	27	19%	12	16%	15	21%
Community based	36	23%	77	33%	51	27%	70	27%	28	20%	11	14%	16	22%
To qualify/finish course	35	22%	60	25%	38	20%	22	8%	1	1%	0	0%	0	0%
Consolidate/expand	30	19%	56	24%	44	23%	66	25%	39	27%	0	0%	0	0%
Move abroad	30	19%	40	17%	27	14%	57	22%	18	13%	3	4%	8	11%
Further profess ed.	30	19%	47	20%	26	14%	46	17%	27	19%	12	16%	0	0%
Promotion	21	13%	15	6%	10	5%	24	9%	7	5%	25	33%	15	21%
Degree*	21	13%	33	14%	18	9%	63	24%	39	27%	18	24%	3	4%
Hospital based	4	3%	9	4%	29	15%	57	22%	33	23%	15	20%	0	0%
Stay in practice	1	1%	7	3%	2	1%	11	4%	2	1%	0	0%	0	0%
Get a job	0	0%	12	5%	18	9%	63	24%	55	39%	3	4%	0	0%
Leave nursing	0	0%	0	0%	0	0%	12	5%	5	4%	0	0%	0	0%
Have a job	0	0%	0	0%	0	0%	0	0%	5	4%	0	0%	0	0%
Teaching	0	0%	0	0%	0	0%	0	0%	0	0%	1	1%	7	10%
Management	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	6	8%
Part time (family)	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	7	10%
Unsure	20	13%	37	16%	17	9%	39	15%	9	6%	0	0%	9	13%
Other	9	6%	22	9%	22	12%	50	19%	25	18%	5	7%	5	7%
Total responses	278		455		320		625		320		100		77	
Total respondents	157		236		191		264		142		76		72	

* The test of differences between proportions compared the proportion of answers in this category at point A (start) and point F (6 months post) they were found to be significantly different ($p < 0.05$).

The data in table 34 suggest that the students perceive themselves as lifelong learners. The desire to study for a degree is constant at A and B with a dip at C and then increases significantly to a maximum of 27% of respondents at the end of the course and is sustained for the qualified diplomates. Other students and diplomates are keen to further their professional education, and one third of diplomates would wish to have gained promotion two years after qualifying. Few expressed the desire to leave nursing, indeed none of the qualified diplomates suggested this, and those who indicated this towards the end of the course, suggested that this would only be the case if they could not secure a nursing post. Many students across all access points were keen to consolidate their knowledge and experience. As a student at the end of the course commented:

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> *"I aim to consolidate my training by gaining much practical experience working as a qualified nurse. I would like to take my education further by studying for a degree. But long term, I would aim to use my skills in working voluntarily overseas."* [121534]

Those that were keen to work in the community appeared to feel it was necessary to first gain experience in the hospital environment, as the following quote from a student, half way through the branch programme illustrates:

> *"I would like to work in the community in the future but for the first couple of years I would like to gain experience in a ward environment to prepare for that."* [111550]

This would appear to contradict the notion that the course is able to prepare practitioners for direct entry into a community post upon qualification. Few practitioners secured community nursing posts at qualification although a number desired this. As suggested in chapter 5 there is currently not the structure available in the community for students to be able to do this.

Section Summary

Generally students perceived the course to have prepared them well to commence their first posts as qualified nurses, although at different times on the course up to one quarter of respondents felt unprepared for practice. The courses were criticised for being poorly organised and lacking in practical skills. However, the broader, research based academic input was valued together with the questioning and analytic approach that was fostered by the course. Interpersonal skills, life sciences and practical skills were felt to be those subjects that would be of greatest help in the practice environment. Life sciences and practical skills were also cited as subjects that were required in greater depth. Indeed, practical skills were consistently identified as an aspect of the course requiring attention. Research, psychology and sociology were unpopular subjects, and were often identified as being poorly taught. Supernumerary status was valued for its learning opportunities and its provision of a more nurturing environment, but not feeling part of the team was a distinct disadvantage. Rostered service did not provide as many opportunities for learning but students welcomed more integration into the ward team. It would appear that teachers should have good theoretical and practical knowledge and to some extent be clinically credible. Their greatest role however is in supporting the student, and student centredness was valued. When the early students were asked for their projected future career plans, the priority in both centres was to gain community experience or specialise. The desire to continue their education by studying for a degree gains popularity as the course progresses. By the end of the CFP and the middle of branch the community retained its attraction as a career focus although, with the clear perceived need to consolidate and expand their experience before embarking on a community post. It would therefore appear that the course has yet to provide the means for direct entry into a community post.

The majority of those asked had encountered a positive nursing role model. Teachers maintained their influence upon the students throughout the course, although mentors and staff nurses became more influential as the course progressed. The qualities valued in a nursing role model included inter-personal and professional skills and a caring attitude. The students perceived the unique role of the nurse within the multi- disciplinary team as giving direct care and liaison whilst for the qualified diplomate it was characterised by twenty four hour contact and an holistic approach. Many students felt it necessary to 'fit in' and compromise their values and beliefs, although this decreased as the course progressed. Some suggested that it was easier to challenge other multi-disciplinary team members than nursing colleagues, and were prepared to be fierce patient advocates in this respect.

The students began to see themselves as nurses as the course progressed, but not for the first 18 months or so. A lay image of nursing persisted, such that the students equate practical and clinical work with being a 'nurse'. Respondents early in the course did perceive themselves as 'different' to 'traditionally' trained nurses, and identified an increased theoretical knowledge and less practical skills as the differences. As the students neared qualification however, for some the 'thirst for change' in Project 2000 nurses was a distinguishing feature, whilst others perceived less difference between themselves and traditionally trained colleagues suggesting that they were the same. The importance of gaining practical experience diminished as the course progressed and any practical skills deficit identified by the newly qualified nurses was an initial skills deficit only.

3. 4. THE STUDENTS' TALE: OVERALL SUMMARY

Students' perceptions of nursing changed and shifted as the course progressed. There was a fundamental shift in the philosophy from sick to health nursing (Macleod Clark 1993). Students initial perceptions of nursing, rooted in the ill health medical model, with a practical emphasis gave way to a 'health nursing' approach which valued theory and research as a foundation for practice. Patients were placed firmly at the centre of nursing care delivery, and students were keen to act as patient advocates. Basic nursing care was seen as a fundamental aspect of nursing, with senior students and qualified nurses keen to be a 'giver' rather than a 'manager' of care. Inter-personal skills were highly prized and seen as fundamental to the role of the nurse. A rationale for nursing action was seen as important, and research was increasingly valued as the course progressed. Patients were viewed holistically, with holism perceived as vital to nursing. Health promotion was implicit rather than explicit, and was firmly embedded in holistic care. When explicitly identified health promotion was confined to a health education type role with an emphasis on individual lifestyle and behaviour change. This is in keeping with the findings of Lask et al (1994) who identified the poor integration of health education and health promotion into the pre-registration curricula.

The course was perceived to be an appropriate preparation for students and on the whole, to have prepared them well. The broader theoretical knowledge including research based practice was valued. Students also enjoyed their supernumerary status with the increased learning opportunities this afforded. A consistent criticism however was the dearth of practical skills, life sciences input and information about illness and disease. The pendulum was felt to have swung too far. The perceived practical skill deficit, was a source of great concern to many students, providing ammunition for critics and undermining student confidence. The newly qualified nurses confirmed that the practical skill deficit was an initial deficit only, but nevertheless it did not ease the transition process for many of the diplomates as discussed in chapter 4. The perceived lack of life sciences knowledge similarly did not aid students in their practice environments. It may be necessary for the expectations of others to be challenged . What is reasonable to expect of an initial preparation, and how much support and preceptorship is both necessary and desirable for the development of the nurse and the profession?

Project 2000 was intended to address the changing needs of society into the twenty first century by equipping nurses with the necessary skills to work directly in the community. These data suggest that this is far from being realised. Whilst many wanted to work in the community, the perception prevailed that it was necessary to initially gain some hospital experience, and few diplomates secured first posts in the community. As identified in chapter 5 it would appear that the structures are not yet in place in the community for these goals to be realised.

The key role models and influential figures for students included both teachers and practitioners, but teachers were often perceived to be out of touch with reality. Students were concerned as the course progressed that teachers should have clinical credibility, opening the debate of who should teach practice?

Students were gradually socialised into the professional role and were perceived and assessed increasingly as a worker rather than a learner as the course progressed. Learning opportunities appear to decrease once the students change from supernumerary status to rostered service. Resource and structural constraints were a determining factor in this. Students did clearly perceive themselves as professionals within the multi-disciplinary team and were able to outline the unique role of nursing within this. They appeared equipped to challenge and to posses some assertion skills, although these appeared to be more in evidence when acting as patient's advocate within the multi-disciplinary team rather than on a day to day basis with nursing colleagues. There was often a strong desire to 'fit in', described by some as a survival tactic. Colleagues were often responsible for completing the students practice assessments and any attempt to 'rock the boat' was perceived as a potential threat to a 'good report'. These data do suggest however, that the need to compromise to 'fit in' diminishes over the course. Students towards the end of the course, and those newly qualified felt more able to practice as they would wish. The majority of students perceived themselves as different to traditionally trained nurses. The thirst for change and the increased theoretical knowledge base together with less practical experience were identified as the major differences. However, 'traditionally' trained colleagues were also perceived to be changing to meet the increased needs of society, and are updating their knowledge and skills, to the extent that the gap is already closing. Students at the end of the course and qualified nurses were more likely to suggest there was little difference between themselves and 'traditionally' trained colleagues.

Chapter 4:

Project 2000 and the Philosophy and Practice of Nursing: The Qualifiers' Tale

INTRODUCTION

The material presented in this chapter offers unique insights into the nature and discipline of nursing from the perspective of the newly qualified Project 2000 diplomates. The data have emerged as a result of analysis of questionnaire responses and interview transcripts derived from 78 questionnaires completed 6 months after qualification and twenty in-depth interviews which took place seven and eleven months after the course was completed. There were striking similarities in the data collected from each of the case study centres. Where between centre differences were observed these are indicated in the text.

The findings indicate that the newly qualified nurses were able to clearly articulate their feelings and beliefs about nursing and to reflect on the impact of the Project 2000 course. The data are presented in this chapter under five main headings, each of which relates in different ways to the aims and objectives of the research.

1. **Demographic data**

2. **Newly qualified Project 2000 diplomates' perceptions of the nature and discipline of nursing**

3. **Newly qualified Project 2000 diplomates as professional practitioners within the multi-disciplinary team**

4. **Reflections on the Project 2000 course as a preparation for practice and socialisation into the professional role.**

5. **New roles and responsibilities-the need for preceptorship and support**

4. 1. DEMOGRAPHIC DATA

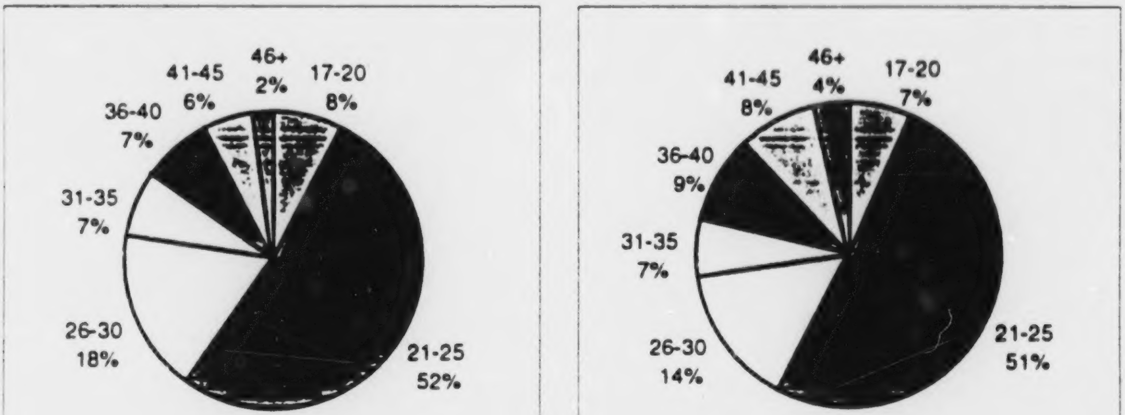
The data presented in this chapter are derived from questionnaires (n=78) completed by qualified diplomates and interviews with a sub sample of ten diplomates in each centre drawn from the returned questionnaires. The breakdown of these samples by demographic characteristics are presented below. The demographic characteristics of the whole sample (at D) from which the questionnaire respondents were drawn, are presented adjacent to the diplomate questionnaire sample to identify the similarities and differences between the two.

As outlined in chapter two the 'elite bias' could be identified here as a potential threat to applicability / external validity. People who responded to the postal questionnaire following completion of the course, and those who agreed to participate in an interview with a member of the research team may be the most articulate, accessible, or high status members of the group. What is striking here however, particularly with respect to those who returned their completed questionnaires (less so the interviewees) is the similarities in their demographic details when compared with those of the cohort as a whole.

Questionnaire Respondents

The majority of the questionnaire respondents were under thirty, this is however consistent with the whole cohort from which the sample were drawn.

Age of Respondents

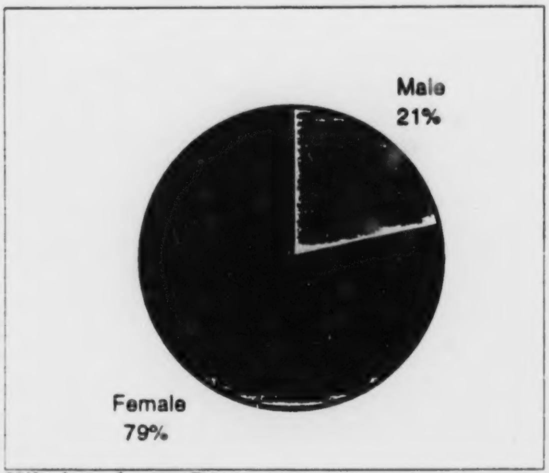


Whole cohort (D)

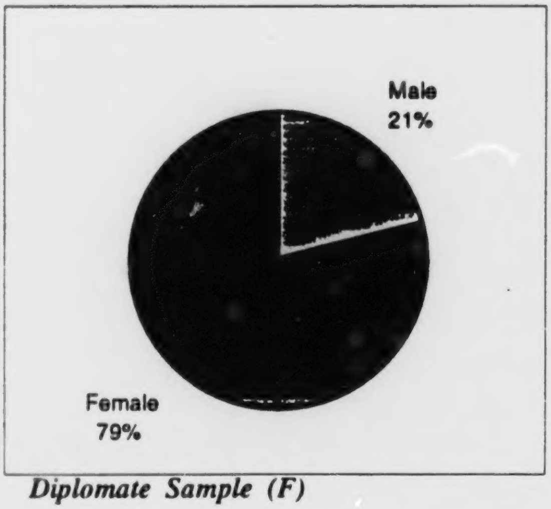
Diplomate Sample (F)

Gender of Respondents

Over three quarters of respondents were women, this is the identical picture for the cohort as a whole.



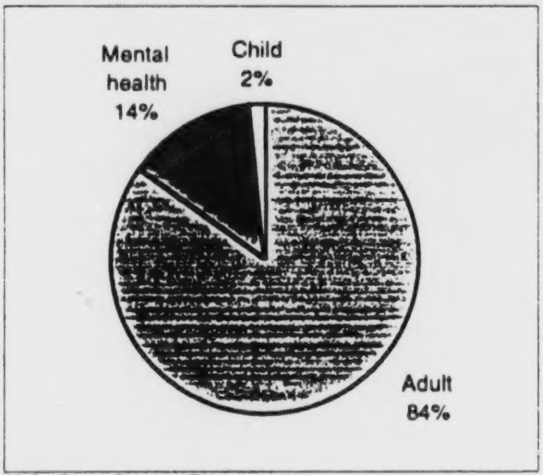
Whole cohort (D)



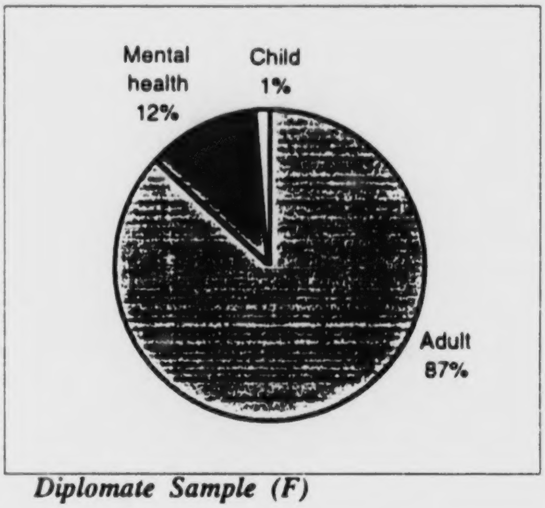
Diplomate Sample (F)

Branch

The proportions in the pie chart below are consistent with the cohort as a whole, with over three quarters undertaking the adult branch programme.



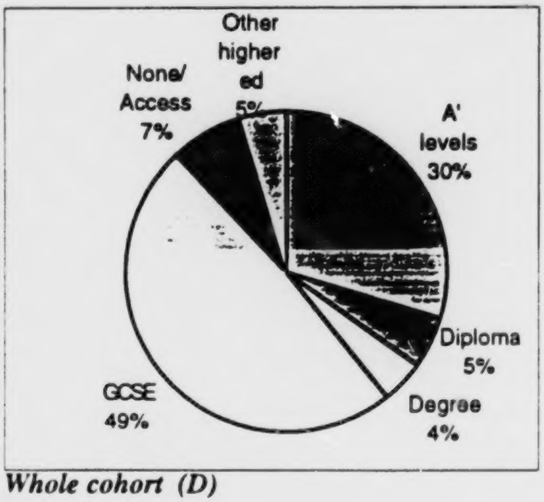
Whole cohort (D)



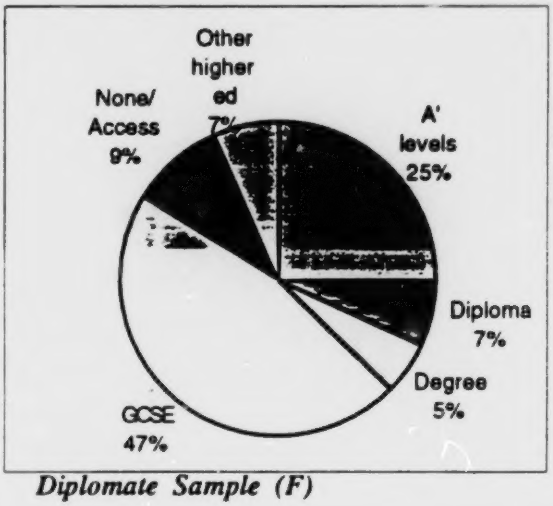
Diplomate Sample (F)

Qualifications

The qualifications of the F questionnaire sample, are not dissimilar to those of the whole cohort, with the majority having GCSE as their highest level of qualification.



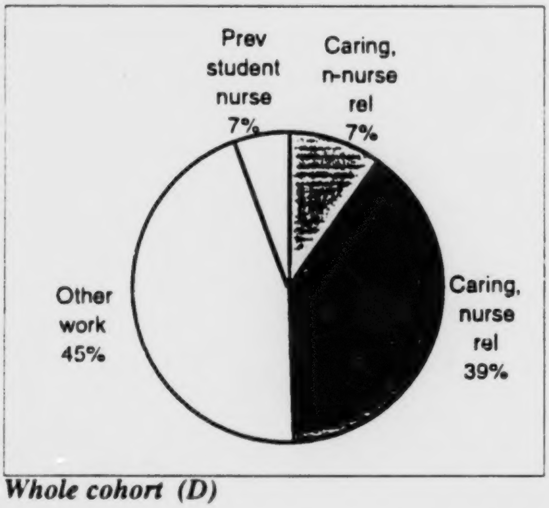
Whole cohort (D)



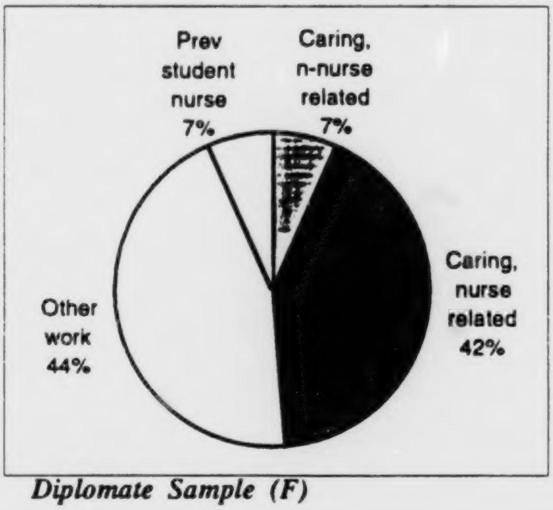
Diplomate Sample (F)

Previous Work Experience

Finally, the previous work experience of those in the qualifier questionnaire sample are proportionately the same or similar to the cohort as a whole. All had undertaken some form of paid work, with nearly half the sample in both the whole cohort and the diplomate sample having undertaken some previous nursing work.



Whole cohort (D)



Diplomate Sample (F)

In summary, these characteristics when compared with the original whole cohort samples (at questionnaire D) showed no significant differences, suggesting that despite the poor response rate the questionnaire F sample was representative of the cohort as a whole.

Interviewees Demographic Details

From the returned questionnaires ten diplomates from each centre were invited to participate in an interview with a member of the research team (for more details see chapter 2). The demographic details of this sub-sample are presented below.

Table 35: Demographics of Interviewees

Demographic Variables	Centre 1 (n=10)	Centre 1 %	Centre 2 (n=10)	Centre 2 %
	n	%	n	%
Age				
21-25 years	7	70%	4	40%
26-30 years	3	30%	3	30%
31-35 years	0	0%	1	10%
36-40 years	0	0%	1	10%
46-50 years	0	0%	1	10%
Gender				
Female	6	60%	8	80%
Male	4	40%	2	20%
Branch programme				
Adult	7	70%	8	80%
Mental Health	3	30%	2	20%
Qualifications				
None / Access	0	0%	1	10%
GCSE	3	30%	6	60%
A Level	5	50%	2	20%
Higher education	2	20%	1	10%
Previous work experience				
Caring-nursing related	5	50%	5	50%
Previous student nurse	0	0%	3	30%
Other work	5	50%	2	20%

4. 2. NEWLY QUALIFIED DIPLOMATES' PERCEPTIONS OF THE NATURE AND DISCIPLINE OF NURSING

The diplomates were clearly able to articulate their own personal philosophy of nursing, and to detail those aspects of their role that were most important to them. These data primarily inform aim two by describing how the course may have influenced students perceptions of the philosophy and practice of nursing.

Primarily nursing for the diplomates interviewed was focused on the patient, and involved communication skills to foster coping, give support and facilitate recovery within the context of quality care. Practice was also seen to be broad ranging and many suggested it was holistic in nature and should be based on up to date research. As one staff nurse summed up:

> *"I would say it is to look at the patient as a whole being and to help them maximise their potential, and to include their relatives in that, and also include all the patient's sort of other facets to their being so that you are not just looking at them as a person in bed. "* [261617/2/15]

From the questionnaire data, the main priorities for the staff nurses (Q085) included the delivery of good quality care, and high standards. Safe practice and patient centred care were also considered to be important by the new diplomates. See table 36 below:

Table 36: Q085 Diplomates' Priorities In Practice

	Centre 1		Centre 2		Both	
Category	*n*	%	*n*	%	*n*	%
Good quality care	35	67%	16	64%	51	66%
Safe practice	13	25%	3	12%	16	21%
Communication	9	17%	3	12%	12	16%
Holistic approach	7	13%	5	20%	12	16%
Gain knowledge/experience	6	12%	4	16%	10	13%
Assessing needs	1	2%	2	8%	3	4%
Advocacy	1	2%	1	4%	2	3%
Other	1	2%	0	0%	1	1%
Total responses	73		34		107	
Total respondents	52		25		77	

More personally the staff nurses interviewed perceived nursing as a professional occupation, and felt that it was important for nurses, to have a good theoretical background, be assertive, questioning and respected by colleagues, and to remain up to date and to continue learning. The need for an holistic approach to care was also identified and this is subsequently explored further in the interview data (see 'Nursing as holistic' within this section).

The Patient as the Central Focus

Those interviewed were quick to establish that they were there for the patient, and that it was the patient who came first. Without exception all nurses interviewed in both case study centres suggested this was fundamental to their view of nursing. As one staff nurse in study centre two commented:

> *"I'm for the patient first middle and last. I don't care about anything else that's happening, as long as the patient's happy and the patient's got what they want then I'm happy at the end of the day."* [251630/2/20]

Care was tailored to the patient's needs where possible, and time was spent in individualising any standard care plans that there may be on the ward. Involving the patient in their own care planning and establishing their wishes and needs was also seen to be important. Participation in care appeared to be part of a guiding philosophy for many of those interviewed, and the need to respect patients and their wishes was paramount. A staff nurse in centre two summarised her feelings as:

> *"Nursing for me therefore is respecting what a patient wants, doing the best you can for them in carrying out their wishes, and not forcing your views on how you think they should be nursed."*. [251621/2/25]

Allied to this respect for patients was the desire to ensure that other professionals did the same which in practice may require the nurse to act as an advocate for the patient. A diplomate in centre two reflected:

> *"Also speaking up for a patient. When doctors come in and start pulling them about, if they are in a lot of pain or they start carrying out procedures and the patient is yelling out in pain but the doctor carries on, it is saying, 'I am sorry but I am not going to carry on until you give them more anaesthetic or you call it a day'. (...) It is speaking up for the patient and being assertive on their behalf if they cannot themselves, if they are too frightened."* [251621/2/26]

Another staff nurse working on an acute mental health unit in centre one commented:

> *"Just because clients really are that important to me -not just these ones, but the ones who come after that. (...) At XX (a different acute unit) I did speak up for people. I think it is a more deprived area than ZZ and you had a lot of women who had crap lives - really horrific things happened to them and people were trying to sweep it under the carpet. You were like a demon, you were such an advocate."* [112665/41]

Central to many of these guiding principles was the concept of caring, which was fundamental to the practice of many of those interviewed. A staff nurse who worked in intensive care suggested that when you removed all the high tech nursing it was the caring that was left:

> *"when it all comes down to it the very basic thing is all those gadgets that are up on the wall and down the side of the bed, if you took all of them away I've got somebody who is lying in a bed and needs to be washed, who needs to be fed, and needs to be talked to, and that is what is simplistic - caring for our patients. It is very simplistic, but that is what I do"* [251620/2/22]

Caring may manifest itself in basic nursing care and through communication with patients. Another staff nurse in centre two also suggested that communicating with patients was a very important aspect of the nurses role:

> *"sitting down with the patients and talking to them, (..) is one of the most important things we do. I did not think it was that important but it really is, especially with the long-term patients. (...) Even if the wash does not get done, their hair does not get washed, it does not really matter, as long as they are alright up here [indicates head]. That's really one of the main things."* [261609/1/23]

A staff nurse working in a nursing home for the elderly in centre one suggested:

> *"My philosophy is mainly (...) for the communication and the caring - that is me. I am not high-tech or anything like that. I would rather do this sort of nursing than working in intensive care."* [111641/24]

A diplomate in centre one felt that the intimacy of nursing was an important aspect, often not understood by others:

> *"intimacy with people. You don't get that in many other jobs. I think that for me at the end of the day, if I had a real in-depth with someone, I feel that probably has been a good day for me.*
> *(...) I would definitely miss that if I moved into another job altogether. That's one thing about the nursing day that you can't explain to your friends that you do. You say `Oh well I sat and had a chat with somebody about such-and-such', but they don't really understand unless you're there and you've got that out of the day, then no-one can really understand."* [111608/39]

Valuing 'Basic Nursing Care'

Allied to the patient orientation of their philosophy of nursing was the way in which they were or were not able to put it into practice. The issue of 'managing' or giving direct patient care was an important one for the diplomates philosophy and understanding of nursing. Central to this issue was the role of health care assistants, and the amount of 'basic nursing care' qualified nurses could and should undertake. All those interviewed in both centres felt that basic nursing care was a unique aspect of nursing and should remain in the domain of the qualified nurse:

> *"I became a nurse because I wanted to be a nurse, not because I could not be a doctor. If I wanted to go to medical school, I could have done so quite easily, but I wanted to be a nurse because nursing is about dealing with people; it is about caring*

> *for people. It is about an intuitive sense for people. (...) I think that nurses need to go back to this hands-on care. (..) As a profession I feel that we are giving over the basic nursing care to unqualified staff, who I am sure can do a very good job but they are not really trained to do it. You can tell an awful lot about people by handling them, you can feel them and touch them, feel if they are clammy. Some people, if they are about to have a heart attack, you can tell by touching them if they are all sweaty and horrible. You look at their bum, at the integrity of their skin. There is an awful lot you can learn by touching people. Then you talk to people, chat to people and people open up on the loo or in the bath. It is amazing as you know. But we are losing that and as professional nurses we like to think that we are above bum-wiping basically. (...) I think nursing is about hands-on care of people, and if you want to do something else that is fine but do not be a nurse. Nurses become managers so they might become very good at organising staff and organising budgets and things like that but should you then call yourself a nurse if that is what you are doing. If that is what you want to do, that is fine, but to my mind it is not nursing. Nursing is people-centred, it is patient-oriented."* [111623/17-18]

From the questionnaire data, 97% (n=76), suggested that high priority should be given to 'basic nursing care' by qualified nurses (Q048). The comments associated with this question support the interview data by suggesting that undertaking basic nursing care gave an opportunity for the qualified nurse to communicate and build relationships with patients. In centre two however, it was also suggested that wider structural issues such as skill mix and a shortage of trained nurses, prevent basic nursing care being given by qualified nurses, who are supervisors rather than givers of care. See table 37 below:

Table 37: Q048 Importance of 'Basic Nursing Care': Comments

	Centre 1		Centre 2		Both	
Category	*n*	%	*n*	%	*n*	%
Opportunity for communication	15	35%	9	90%	24	45%
Important to patient	12	28%	1	10%	13	25%
Foundation of care	11	26%	5	50%	16	30%
Structural issues prevent	7	16%	9	90%	16	30%
Low priority	6	14%	3	30%	9	17%
Promotes independence	1	2%	0	0%	1	2%
Other	12	28%	3	30%	15	28%
Total responses	64		30		94	
Total respondents	43		10		53	

In the interview data there were several strands to the arguments put forward by qualified nurses for them to have more of a role in basic nursing care. These included, as suggested above, for the purposes of assessment, for building relationships, and for increased knowledge of the patient. The time spent with patients in giving hygiene care was felt to be an important opportunity for assessing the patient:

> *"I do see it as important (...) because I think you can't assess somebody unless you get involved in the basic needs really. Personally, that's what I feel."* [121634/16]

Not being involved and having a more managerial role, the staff nurses felt was detrimental to patient care:

> *"At the end of the day, we're the ones that are qualified; we're the ones that are trained to be able to assess the patients and to give the care, yet if we're not there then it's the un-qualified that - they are not qualified to do it, you know? They might be qualified to do basic nursing care, but to listen to them and to - if they're for example worried about social circumstances when they go home, they don't know to get on to a social worker, to do social worker referral to try and get somebody to see them and do a financial assessment, to get an occupational therapist to come and do an assessment on them to see how much they'll manage when they go home or what they want. I'm not putting unqualified staff down at all, it's just that it's wrong that they are being - they are expected to do the job now of the qualified nurse, yet they haven't been trained and they're not being paid for that."* [121622/18]

Basic nursing care provides the time and opportunity to find out about patient worries, give any education necessary, and build up trust and rapport, yet often structural constraints, such as poor skill mix meant that this was not achieved as a staff nurse in centre one reflected:

> *"because of the ratio you find that it's the unqualified staff that are doing all the basic nursing care, and I'm supposed to write up for the day about a patient, and I can't say what the skin condition is like, if they've got any pressure sores; I can't say what their psychological state is, following an MI, are they still anxious or have they come to terms with it; I think it is a vital part, your basic nursing care. It's a good chance to find out about your patients, to give them any education, because it's the time when - usually, it seems so trivial but it's the time when they actually come out with all the things that are really worrying them, and I'm missing it all."* [121622/12]

The staff nurses felt that they were becoming the managers of care rather than the givers of care, and for some this was in stark contrast to their experiences as students when there was the opportunity to build relationships with patients. One staff nurse wondered therefore whether the current nurse education was at odds with the current role of qualified nurses:

> *"If we are talking about quality of care and audit of quality services, surely I would much rather be looked after by somebody who has had three years of training and a bit of experience, than somebody who has not, no matter how good they are.(..) It sounds very conceited to say that it is to the detriment of the patient but in some ways it is. The patient might not be looked after as well.*
> *(..) you organise the patients' care, you liaise with the doctors and everybody else in a multi-disciplinary team but then somebody else does all the work. So you really do not have much say in that patient. You might have done all the paperwork but not actually seen what the patient is like.(..) So in that sense the further nursing is going away from the bedside, is it nursing any more? I wonder sometimes if it is appropriate and I wonder if the training of nurses is appropriate to the hands-on care."* [111623/19]

Nursing as holistic

Many of the staff nurses interviewed perceived nursing as broad ranging and holistic. They felt that they would not being doing their jobs properly if they did not attempt to view their patients holistically, and where possible help with those broader influences on health and ill health. This may be viewed as an aspect of health promotion (see Tones 1990, Latter 1995), although again it would not be described as such by the diplomates. A diplomate in centre one suggested that nursing is a lot more than giving physical care:

> *"It's not just giving them physical care. I like holistic care and I wish everywhere, every area of nursing, was holistic and implemented primary nursing, because I think that is the best. I hate task-orientated nursing, which I feel I'm doing at the minute, because I like to get to know a patient, get to find out all about them and, using my skills as a nurse, then I can provide the physical care; using my inter-personal skills I can help them psychologically and socially, and I don't just see nursing as a physical kind of career."* [121622/13]

Another staff nurse from a haemodialysis unit in centre one, echoed these feelings and suggested that she would rather feel that she was a having a therapeutic effect rather than purely caring for the physical aspects:

> *"I would rather be thought of as being therapeutic to somebody's situation or to how somebody feels about themselves. I think a lot of what I want to do it based around people's - not people's physical ailments or whatever but about how people see themselves, how people want to be seen - taking care of the person rather than taking care of the disease that they have."* [121625/28]

For many this view of nursing had been passed onto them throughout the course, and was not part of their understanding of nursing at the commencement of their course. A staff nurse who had previously undertaken fourteen months of a 'traditional course' some years before, commented that at the start of the Project 2000 course:

> *"I did not really have the concept that life styles and jobs, work, mortgage problems, can all change people's health when they are in hospital. It can all have - I can't think of the right word - it can all alter how they are feeling, how they are when they are in hospital. And Project 2000 did help that, definitely. It helped give a wider concept to the person rather than just go through the illnesses and the disease processes. It showed that there was something much more to a person than just that, and that was good"* [261617/2/15]

For one nurse however attempting to care for patients holistically was a source of stress and frustration when outside influences could not be changed. Partly as a result of this she had changed ward areas:

> *"on X ward, I used to get very stressed but that was because you were not only thinking of the medical condition, it is this term "holistic", isn't it? You are trying to cope with all the other sides and there is only a certain amount you can do for a person. We used to get a lot of psychological problems with a lot of people but there is no way in which you can sort them out on a week's stay in hospital. So they go out and you would know that they were not a whole person because they had that imbalance because psychologically they were not well adjusted. There is a limit but it is frustrating because you know that perhaps they should have been referred to a psychologist. X are booked up and have so many patients on their books. They are not able to give the input that should be given, I do not feel, so you are sending out patients who you know need much more and yet you are unable to give it. That is extremely frustrating."* [261610/2/13]

Health Promotion By Any Other Name

This section seeks to illuminate the issue of the Project 2000 qualified nurses' perceptions of health promotion in nursing. An overwhelming finding was that these nurses' understandings and descriptions of health promotion were almost exclusively implicit rather than explicit. For example a theme which emerged strongly was that of the facilitation of recovery. This was espoused by the diplomates as quite different from simplistic notions of 'making people better'. Together with aspects of their philosophy presented above, it could be conceptualised as health promotion in its broadest sense - that is helping patients to maximise their potential, facilitate coping, and to improve their state of health - although the diplomates themselves did not label it as such. A staff nurse on an acute ward (mental health) in centre two suggested that her role was :

> *"to facilitate them to explore the problem in their own way and to find ways of dealing with it or coping with it. I will do that through support, counselling and through the individual sessions that we have. I will find as much information and offer them as much support as I can, always giving them time to ventilate their feelings. That is without doubt my major role and that is what takes up the largest part of my day, second to documentation. It is never to give advice in any way, because I certainly do not do that, or I would like to think I will not do that. If I give advice it will be like health promotion or something like that but otherwise it is really to foster their own ability to deal with it in their own way."* [252623/2/18]

Interestingly 'health promotion' was labelled as giving advice, whereas the whole of this staff nurse's description of her work is arguably health promotion or health nursing (as suggested by Macleod Clark 1993). Similarly a diplomate working in the same area in centre one commented:

> *"I can get involved in trying to get them to come to the answers of how they can help themselves. That might be by me offering them some suggestions or guiding them in a way so that they come up with some of the answers. That is basically what I want to do: I do not want to tell them what they should do. That is not my job. I see my job as being that they should eventually, after talking to me and whoever, should come to the decision that it might be helpful if they did this, or if they could get themselves into a position where they felt well enough they could try doing that, and empowering them to do that.(..) What I want to do is really, at the end of the day, to be able to say that this person is coping, being able to cope with life quite well."* [122667/15]

Facilitating recovery was also often cited as one of the more enjoyable aspects of nursing, seeing people improve and go home. A staff nurse from an acute mental health unit in centre two reflected:

> *"There are loads of things that are enjoyable and positive. ... Those times where I am with a patient and we are exploring things and where we seem to be getting to the bottom of things and seem to be resolving problems or helping that person to find other coping mechanisms, that is tremendously satisfying and fantastic. As it should be, that is the most satisfying aspect, because that is what the job is about really. It is satisfying that I am facilitating someone to improve their life in some way or to get back to a normal life. It is tremendously satisfying and I don't know if there is anything else that I could do that could compare with it, or I cannot think of anything"* [252623/2/27]

Another staff nurse from a medical ward in centre two suggested that relative participation in recovery or peaceful death was particularly satisfying and a staff nurse in centre one reflected:

> *"just seeing people - it so basic, but seeing people get better. Seeing people come in - and there's cases that stick in my mind, where people have come in that have been really ill and you don't think they're going to pull through, and yet you see them walk out, and you think 'It's great; its taken a long time but we've got them there' and that's what makes the job worthwhile at the end of the day."* [121622/28]

The diplomates felt that it was important to view the patient holistically, as outlined above. Seeing the patient in the context of his wider environment, and the socio-economic influences on health were deemed crucial. As suggested earlier this may also be perceived as 'health promotion', by any other name, although it was not viewed in this way by the diplomates themselves. A staff nurse in centre two highlighted the holistic approach to care with an example from her recent practice where it was necessary to take other factors into consideration:

> *"this poor guy's marriage broke down, so from caring for this poor bloke with a chest infection or whatever it was, from looking after this chap and getting him over his acute illness, we went from looking after that to looking after his social problems. That is what nursing is. It is not just getting somebody washed and dressed; that is one facet of it. The other facet is being aware of what goes on that affects the patient, and being able to react to this with the patient."* [251620/2/22]

As suggested above, much of what could be deemed health education/promotion (Tones 1990, Latter 1995) was discussed by the interviewees in the context of facilitating recovery and providing holistic care. In the questionnaire data however health education / promotion was addressed more specifically. When asked directly "In what ways are you able to work as a health promoter?" (Q088), the narrower, more traditional view of health education prevailed. Giving advice and information and teaching and educating were the most popular answers (24%, 14% and 20% respectively). Attempts to get at the broader health promotion role of the nurse largely failed with over a quarter of respondents not understanding the questions ("Which policies within your work area promote health?" (Q089), and "Can you think of any policy to promote health that you would

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like to see implemented?" (QO90)). Those that did respond adhered to individualistic lifestyle related issues, with no reference to political, socio-economic, or environmental influences. For both questions the answers were smoking, diet and exercise. Structural and resource constraints at practice level were deemed to hinder the implementation of health education and health promotion (Q019), but this generally meant staffing shortages or a lack of educational materials rather than any recognition of broader constraints. Patient reluctance and lack of compliance was also seen as a difficulty. Facilitators for the most part were the opposite of the inhibitors. See below for table 38 displaying the inhibitors and facilitators of health education and health promotion implementation:

Table 38: Q019 Inhibitors and facilitators of putting health education/health promotion into practice

	Centre 1		Centre 2		Both	
Category	*n*	%	*n*	%	*n*	%
Inhibitors						
Patient reluctance	31	66%	6	30%	37	55%
Structural constraints	19	40%	12	60%	31	46%
Lack of knowledge/status	5	11%	2	10%	7	10%
Staff act as barrier	2	4%	2	10%	4	6%
Political/socio-economic infl	1	2%	0	0%	1	1%
Facilitators						
Resources available	16	34%	6	30%	22	33%
Knowledge	15	32%	3	15%	18	27%
New philosophy	11	23%	2	10%	13	19%
Motivated patients	9	19%	8	40%	17	25%
IPS/teaching skills	8	17%	3	15%	11	16%
Good patient relationships	4	9%	2	10%	6	9%
Other	4	9%	1	5%	5	7%
Total responses	125		47		172	
Total respondents	47		20		67	

Section Summary

Diplomates who returned completed questionnaires, and those who were interviewed perceived nursing as caring, patient centred and holistic. Safe practice, quality care and high standards were deemed important. Nursing was perceived as a profession and diplomates suggested a questioning, assertive approach with up to date theoretical knowledge and a desire to continue learning was crucial. Respondents repeatedly suggested that the patient was fundamentally important and partnerships and participation in care by patients was highlighted. The diplomates valued and were keen to practice advocacy and basic nursing care. The latter was seen to be important for assessment, facilitating communication and building relationships with patients. The diplomates were keen to give 'basic nursing care' care as well as manage care. However in centre two some wider structural issues such as skill mix and a shortage of trained staff prevented the delivery of 'basic nursing care' by qualified staff.

Patient care was place firmly in the context of the wider environment through the concept of holism, which was seen as vital to the diplomates understandings of nursing. Health promotion appeared integrated into care in a way that prevented easy definitions of the term. Indeed when seeking to define their role and work under this label, narrower definitions of health education prevailed. The broader implications of health promotion were embedded in other concepts such as facilitating recovery, and holistic care, and did not emerge under the health promotion label. Health promotion appeared to send diplomates down the individualistic, victim-blaming, 'lifestyle' route, which was at odds with their conceptualisation of 'facilitating recovery' and 'holism'.

4. 3. NEWLY QUALIFIED DIPLOMATES AS PROFESSIONAL PRACTITIONERS WITHIN THE MULTI-DISCIPLINARY TEAM

The findings described in this section inform further aspects of the project aims (aim 2). This section seeks to illuminate their role within the wider context of multi-disciplinary care provision. Many issues raised by the diplomates interviewed appear to revolve around professional issues, and it was clear that many regarded themselves as professionals. One staff nurse reflected that the legacy of the past was at times a hindrance in this:

> *"I have one qualm about good old Florence. Good old Mrs Nightingale from all those years ago made us the doctors' handmaiden, and I am not a doctor's handmaiden thank you very much. I am a person in practice who is - what I do and what I say and what I know I say because I am a professional, and because I am a nurse."* [251620/2/38]

This nurse went onto say that her perception of herself as a professional nurse had been largely fostered by the Project 2000 course, but that some members of the multi-disciplinary team appeared unaware of this:

> *"I think dichotomy is the word I'm looking for - we're given this ideal 'You are a professional person; this is a doctor, this is a nurse. The two come together and they work as a team'. Fine. Except when there is a consultant on the ward, because when the consultant's on the ward all of a sudden I become only slightly better than a domestic, because I'm only a D-grade.(..)That is what I hate, all of a sudden when certain doctors are around, or when certain situations arise, I am expected to revert to an expected role and I don't have that role, because my image of my role is different. Project 2000 has taught me that. Project 2000 taught me I am a professional nurse, but nobody has told the doctors. As far as the doctors are concerned, Auntie Florrie is still alive and well and making ."* [251620/2/38]

From the questionnaire data, the newly qualified nurses suggested that one of the ways in which they would like to change nursing in general, (Q 33) would be to increase the professionalism, assertion and recognition of nursing. At interview another staff nurse suggested that the image of nursing as presented by the traditional course was not appealing, whereas the image of the academic professional nurse was:

> *"I don't think I would have carried on with my nursing if I'd been doing the old-style training. I don't think I even would have started, to be perfectly honest. Because it brought across images of being very much a dogs body, very much the doctors' handmaiden, and that is not me.(...) What I read about Project 2000 was the academic side, this professionalism that was very much put forward about it; the fact that you came out at the end of it not just as a qualified nurse but with a Diploma as well. It had some sort of credibility about it, and the blurb that I had was very much improving - the goal was improving standards, for nurses but for patients as well, and I suppose that is what attracted me."* [111634/36]

Another participant felt that nurses were not very good at defining what they do, and suggested that this illustrated a lack of professional confidence:

> *"It is certainly difficult to define what nursing is or people find it difficult to do that. I do not really feel that it is difficult to define it myself, certainly not to define what I do. But people do not seem to be confident in defining what they do as a job. People who seem to be confident in what they do, they seem to find it all very vague. It is not vague at all. When I actually look down and see what the other qualified nurses do, there are a tremendous amount of skills there but, whereas other professions are very good at defining what they do, nursing is dreadful at defining what it does. That is very detrimental to nursing as a whole, that lack of confidence. It is a great lack of confidence there and a lot of it is brought on ourselves as nurses."* [252623/2/23]

Another diplomate suggested:

> *"nurses are almost their own worst enemy, to be honest; they are forever putting themselves down, and if they pulled themselves up a bit they would maybe get the recognition that they do deserve."* [111634/32]

For another, perceptions of nursing as a profession had been discovered on the course:

> *"We have a lot more responsibility than I thought we would have, before I started my nurse training. I thought we would be the doctors' little helpers and I remember that being drilled out of me only two months into my training. "We are not doctors' helpers!" - OK, OK!"* [261609/1/12]

The role of nurse within the multi-disciplinary team was explored within the questionnaires (Q097). Nurses were felt to have unique 24 hour contact with patients, were best informed about patients and provided an holistic approach to care. See table 39 below.

Table 39: Q097 What if anything does nursing contribute to the multi-disciplinary team that no other group can?

	Centre 1		Centre 2		Both	
Category	*n*	%	*n*	%	*n*	%
24 hour contact	18	37%	11	50%	29	41%
Best informed	15	31%	4	18%	19	27%
Holistic approach	14	29%	7	32%	21	30%
Intimate relationships	12	24%	2	9%	14	20%
Patient advocate	3	6%	6	27%	9	13%
Central/pivotal role	2	4%	1	5%	3	4%
Co-ordinating role	1	2%	1	5%	2	3%
Specialist skills	1	2%	0	0%	1	1%
Other	3	6%	0	0%	3	4%
Total responses	69		32		101	
Total respondents	49		22		71	

At interview, it was seen to be important that nurses should utilise their knowledge and expertise as professionals within the team, to influence others and question and challenge practice. As one staff nurse commented:

> *"It is very valuable to pass that information on and to pass your thoughts on as a professional nurse who knows his patient very well and very intimately."* [252623/2/12-13]

She went on to suggest that it was important for nurses to feel confident to express their opinions within the multi-disciplinary team :

> *"I see the other professionals as one professional within a team and I am one professional within a team and I do not see any difference between any of us. We all have our own respective job. One person has input from different people on the multi-disciplinary team and every input is as important as the other one, and we all have our own professional views on it. We should present it to a multi-disciplinary team in a democratic way but it often does not happen like that. (...) That is because a lot of people do not express any thoughts that they have, any professional opinions that they have from a nursing point of view. They keep quiet and let the consultant make all the decisions, which is fair - the consultant takes ultimate responsibility and he should make the decision - but you should throw your thoughts out to be discussed, to be rejected or to give some value to decisions that are made."* [252623/2/23]

She felt confident to do this as did others, reflected in the following comment from a staff nurse on a care of the elderly ward:

> *"I'm not frightened to ask or to question why the doctors do things. (...) We get that with certain procedures - like catheters - we're not frightened to - the doctor wants one thing and we think it's not right for them, we will say 'We don't feel this is right, we don't feel that we can really deliver this kind of care because it's totally outrageous'."* [251630/2/38]

Another staff nurse in centre one commented that she did not compromise because she was there for the patients:

> *"you learn to be assertive and to stand up for yourself. There's quite a few times they've gone to do something and I've said no because the patient doesn't want to do that; why should they if they don't want to do it? And 'What do you mean? We always do it like this.'"* [121634/9]

Other pertinent professional issues included the necessity of updating one's knowledge and practice, and the importance of being non-judgmental, and respecting patient confidentiality.

Perceptions Of Themselves As Practitioners

This section explores the diplomates perceptions of themselves as qualified practitioners from the questionnaire and interview data. This informs aspects of aim four by providing the diplomates own perspective of themselves as professional practitioners, as an adjunct to the practitioners perceptions explored in chapter 5.

The Questioning Nurse

At interview the issue of research was raised by several staff nurses, both as a way of improving nursing practice in general, and as a way of effecting change in their own practice areas. Knowledge of research was also something that was often expected of them by others, and some 'traditional' nurses were keen to utilise this knowledge. As one diplomate commented:

> *"I think a lot of them expect you to bring all sorts of research-based nursing into practice. In the interviews that I went to as a D-grade, everyone said you have had a lot of research in your training, how would you present that research to the ward or how would you change something with research-based evidence? They are much more into that now."* [251621/2/22]

A staff nurse in centre one suggested that research was central to her practice, although patient orientation was always the most important:

> *"I am seen as a bit of an odd bod on my ward because I think research is very important, not just for the sake of it; it's got to be specific to something that we are doing on the ward, and I think yes, you should take into account all the other aspects of nursing as well, but at the centre of it is the patient."* [111634/25]

That research could be used to change practice was picked up by a staff nurse at interview, who suggested it is the way of the future:

> *"I would say that the research-based knowledge is having a hell of a lot of impact on care (...)- to raise standards of care, to bring standards in, and to deliver the best care to the patient. I update all the files on the wards. I bring in lots of research on wound care. I go on all these study days so that I can use the knowledge that I learn from them to bring to the ward setting. So I am actually able to implement change in that respect as well, because I can prove that what I'm doing and what I'm saying is feasible and good for the patients because it's being backed by regular research, and up-to-date research. I'm not too keen on using maybe a piece of research that was done 15, 20 years ago, because it is quite often updated since then. (..) research is a good thing, and I still think it is the way of the future."* [251630/2/29]

From the questionnaire data, the majority of respondents suggested that they were able to relate research findings to their own practice (62% in centre 1 and 72% in centre 2). The most popular areas included pressure area care and pre and post operative procedures. The latter specifically included giving information to reduce anxiety and reduce post -op pain. The perceived benefits of utilising research were the provision of quality care with improved patient outcomes. For those who had been unable to relate a research finding to practice (38% in centre 1 and 28% in centre 2) the perceived barriers included lack of opportunity, resistance by colleagues and lack of time.

Themselves as Potential Change-agents

The interview data revealed that many of the qualifiers did see themselves as potential change agents. They believed that they had been taught to question others during the course, as a diplomate on a medical ward in centre two commented:

> *"So in that way we were taught to question and I am very cautious and careful anyway. I probably get on people's nerves and they say, 'Not her again!' but I am always asking why I should do something in a certain way. I think in that way it was drummed into us from the very beginning and the tutors were very good and very aware that things were changing. Patients and relatives are becoming more aware and they said that part of our training was assertiveness training. We did quite a lot of role play.(...) It was helpful to a lot of people because they knew how to ask questions in a different way rather than demanding and saying, 'You must do this!' I think it gave people more confidence than they would have had."* [251621/2/11]

This was also the experience of a diplomate in centre one:

> *"One of the good things about Project 2000 is that it has made me question a lot of things. That is quite good, because I questioned a lot of things anyway before I came, so it fitted in with me quite well."* [122667/14]

Assertiveness, and questioning was felt to be an asset in trying to bring about change in others, as another staff nurse described:

> *"P: Towards the end, I started to realise that I did not want to be like some of the nurses out there and I did not just want to cope. I wanted to be able to change things and the only way to change things is by getting other people to change as well.*
> *R: Did the course teach you how to do that?*
> *P: Yes in a way. I cannot pinpoint exactly how they did but I vaguely remember one tutor saying something like, 'You have got to be able to challenge them but you cannot challenge them if you do not have anything to back it up with, so always make sure you know what you are doing'."* [261609/1/16]

This was also supported by the questionnaire data. The majority of those who responded to the questionnaire suggested that the course had equipped them with the skills necessary to effect change (Q081). There were remarkable similarities between the answers given in centres one and two, therefore table 40 below presents the overall responses, whilst table 41 presents details of the specific skills identified. Centre 2 consistently identified 'Research Base' more than Centre 1.

Table 40: Q081 Extent to which course has equipped nurses with skills to effect change

	Centre 1 & 2	
Category	*n*	%
Has not equipped	14	19%
Has equipped	57	81%
Total	79	100%

NB: 6 cases were unable to answer the question

Table 41: Q081 Skills to effect change possessed by respondents

	Centre 1		Centre 2		Both	
Category	*n*	%	*n*	%	*n*	%
Assertive/questioning approach	26	51%	7	30%	33	45%
Teaching/knowledge base	13	25%	3	13%	16	22%
Communications skills	13	25%	5	22%	18	24%
Research base	10	20%	12	52%	22	30%
Confidence	6	12%	3	13%	9	12%
Knowledge /skill deficit	5	10%	3	13%	8	11%
Resistance to change	3	6%	1	4%	4	5%
Resource deficits	1	2%	0	0%	1	1%
Need to 'fit in'	0	0%	2	9%	2	3%
Other	2	4%	1	4%	3	4%
Total responses	77		36		116	
Total respondents	51		23		74	

These skills included an assertive / questioning approach, research based practice, a good theoretical base and inter-personal skills (IPS). Having the knowledge to back up action and knowing the rationale behind practice was identified as another principle passed onto the diplomates by the college. One diplomate also emphasised the importance of this for accountability:

> *"It was always drummed into us from the beginning that one of the reasons for Project 2000 training, and one way in which it differed from traditional, is that you were expected to find out the reasons why you did certain procedures and why you carried them out. At the end of the day, if you are doing a nursing procedure, or you are carrying out a practical skill and something goes wrong and you said you did it because of such and such and you knew the reasons why you did it, you would have a leg to stand on and you had a basis on which to state why you did a certain thing. But if you went ahead and did something and you hadn't a clue why you did it, but just because other people did it, that was no reason to defend yourself."* [251621/2/10]

At interview, it was seen to be important for students and staff nurses not to 'bluff' their way through, and to always ask if they did not know how to do something. Again this was fostered by the course, as one staff nurse illustrated:

> *"you are meant to say I feel I am out of my depth here and I do not know what I am doing. The code of conduct really backs that up as well. We were always quoted the code of conduct over at the school and told you must say if you cannot do something, so we did."* [251621/2/20]

This willingness to admit to things that they did not know, may be one of the reasons that the course has been criticised for deficits in practical skills and confidence in the newly qualified nurses. This is examined further in section four - which explores the diplomates perceptions of the course as a preparation for practice.

Attitudes And Perceptions Of Others

The majority of those interviewed in both centres had experienced some difficulty in their relationships with other members of the team. It would appear that some team members (like those in the Jowett et al study 1994) displayed some particularly hostile behaviour to the new staff nurse, simply because they had come through the 'Project 2000' programme. The questionnaire data again provides an initial overview of this issue. Respondents were asked "What do you think your non-Project 2000 colleagues think of Project 2000 qualified nurses?" (Q091). Over one quarter of responses in each centre suggested that the views were positive and accepting, whilst a similar number suggested that basic skills were perceived to be lacking, and they were perceived as being "full of theory", particularly in centre 2 (19%).

Stigma and Negative Attitudes

As suggested above, there remains a certain amount of 'stigma' attached to the course, and some existing staff appeared to feel threatened, which often made life difficult for the new diplomate. Criticism of the course and the 'products' of the course was also something the new staff nurses had to contend with, as one staff nurse in centre two commented:

> *"I did notice there was a few problems in the first few months in settling in -the health care assistants felt that we were maybe 'Oh God, what are they teaching us in college?', that it was a bit of a lack of common sense.(...) HCAs think that we could perhaps do with a bit more on the practical side."* [251630/2/6]

It was felt that some traditional nurses may have felt threatened by the new diplomates, and that this may in part stem from a lack of knowledge about the course. A diplomate in centre one reflected:

> *"I think the main problem is they feel threatened. They are very threatened by it. (..) It frightens them having people coming along and questioning what they are doing, because I certainly did all the way through my training, and I think Project 2000 gave me the confidence to say 'Well, why are you doing that? Do you have to? Can you not do it another way?', and people have to look at their own practice then, and they don't like doing that.(...A lot of the time, though, they see you as being the academic, coming in as the academic. To me that is because they don't understand the course properly."* [121634/7]

Further stress was encountered in confronting doctors and other members of staff for their negative attitudes, despite (or perhaps because of) the skills in assertion the new staff nurses displayed. Some doctors it seems are unwilling to accept nurses as educated professionals, entitled to an opinion, instead preferring 'handmaidens'. The assertiveness training, and professional values instilled in the diplomates by the Project 2000 course has given them a clear vision of their role, but at the same time has presented this difficulty, as not all team members view nurses as autonomous professionals. Although any difficulty in relationships with colleagues usually disappeared within a few months, certainly at the time it often had a profound effect.

> *"When I first qualified they hated me because I'm a Diploma nurse. I had so much aggro from one of the E-grades on this ward that she will not even leave the keys in my hand. If she had to go for a break she wouldn't go, she'd get a cup of coffee and have it in the office. Only because you have to give the keys to somebody that's got a higher qualification that her, but practice wise has got less experience. (..) She actually felt threatened that I'd take over her job. (..) That was quite difficult. That was more stressful than becoming a staff nurse."* [251608/1/8]

Colleagues Resistance To Change

Staff resistance to change was another difficult area. The Project 2000 diplomates are educated to question and challenge practice, and to utilise research. Some of the diplomates' nursing colleagues offered some resistance to these ideas causing conflict, and at times difficulties and stress for the new staff nurse. One diplomate commented on a colleague's attitude to change and innovation:

> *"There is one or two, well one particular nurse who will not even listen at all. We use the named nurse system here a lot because we can, as there are only nine patients (...) but when this particular nurse is on, she splits the ward down the middle. She is very old style - you have that side, I will have this side, no matter whether they are your patients or not. It is very hard to turn round and say, 'I don't want this side - she is mine!' You can but she will make it hard for you."* [261609/1/15]

And another in centre one reflected:

> *"I mean, there were certain members that criticised and they still do now, but it's only now that I've actually started to find my own feet and I actually like stand my own ground and I can actually turn round and say something back to them and stand*

> *up for myself. But at first, I mean, with first qualifying and just doing some things, I got some horrific criticism from them and usually - I hate to say this - it involved nurses that had been on the ward for about 50 years or whatever - I'm not too sure it was 50! "* [121634/7]

The questionnaire data provide further insight into this via three different questions. In response to the question "To what extent have you been able to influence practice in the area in which you work?" (Q082) the four point scales (table 42) show a mixed response:

Table 42: Q082 Ability to influence practice

	Centre 1		Centre 2		Both	
Category	*n*	%	*n*	%	*n*	%
Able to influence practice	25	48%	14	56%	39	51%
Unable to influence practice	27	52%	11	44%	37	49%
Total	52	100%	25	100%	76	100%

For those who suggested they were not able to influence practice, being too junior or inexperienced was the most frequently cited response (26% in centre 1 and 32% in centre 2). In centre 1 staff appear to be perceived as more open and receptive, and the qualifiers there more willing to challenge others/share ideas (responses to Q033). In both centres however, when asked how they would like to change practice in their work areas, (Q080) the most frequently cited responses were, to change old attitudes and practices (21% in centre 1 and 19% in centre 2) and to increase research based practice (33% in centre 26% in centre 1) and finally to have more individualised care (15% in centre 1 and 15% in centre 2).

Those interviewed suggested that it was somewhat easier to challenge peers, but challenging and questioning the ward sister, was more difficult, at least initially, whilst the staff nurses were finding their feet. The wards appeared to operate on hierarchical levels, and a D grade junior staff nurse was not in a position to challenge sisters or consultants. One staff nurse was researching different pressure relieving mattresses in the library, as she felt the one currently used in her practice area was an infection risk. She was under no illusions however at the difficulties she may face in bringing about any change:

> *"Again, it is not something that I could broach or I do not feel I could broach it with the sister at the moment, because that is her theatre, her water mattress. (...) she will not give a thought as to why she is doing something. It is just that it is done like this and that is that. 'I give the surgeons what they want, they are happy with it and that is that.' That is fine but there are other bits that she should really take on board but you do not mince words with sister. "* [261610/2/18]

However, to have the backing and support of colleagues within the multi-disciplinary team was a source of satisfaction to some. This is explored further in section 4 (supportive environment) below.

Section Summary

The diplomates clearly perceived themselves as professionals and valued the shift towards professional status for nursing. They were keen not to be perceived as doctor's handmaidens and felt nursing had a unique role within the multi-disciplinary team. Nurses were best informed about the patient, provided an holistic approach, and had unique twenty four hour contact with patients. It was felt to be important for nurses to express their opinions to other multi-disciplinary team members and to question and challenge practice. Questionnaire respondents and interviewees valued research, and the rationale behind care that it provided. Research was seen to be one of the major ways through which nursing practice could be changed, and more than three fifths of the questionnaire respondents had related a research finding to practice. For those who had been unable to relate a research finding to practice the perceived barriers included lack of time and opportunity, and resistance by colleagues. The majority also perceived themselves as potential change agents, and felt that the course had equipped them with the skills necessary to effect change in the practice environment. However, working with others in the multi-disciplinary team, who often had different and at times hostile perceptions of the diplomates, was a source of stress for the new staff nurses. Nursing colleagues perceived the Project 2000 students as lacking in practical skills and 'full of theory' , although one quarter were positive and accepting. Challenging doctors and 'traditional' staff was not easy despite the assertiveness preparation received in college, as some colleagues appeared resistant to change and innovation. Around half of respondents had not been able to influence practice in the area in which they worked. They knew which areas of practice they would like to change (Old attitudes, more research and individualised care), but often felt too junior or inexperienced to accomplish this.

4. 4. REFLECTIONS ON THE PROJECT 2000 COURSE AS A PREPARATION FOR PRACTICE AND SOCIALISATION INTO THE PROFESSIONAL ROLE

Whilst reflecting on their own philosophy of nursing and speaking of their experiences since they qualified the diplomates regularly commented on aspects of the Project 2000 course that they had recently completed. This section seeks to inform some of the aims of the project by establishing the part played by the course in preparing the student for their role as professional practitioners. The contribution made by the course towards the process of socialisation into the professional role is also addressed (aim five). The general view was that as the course was still in its early days, some problems were inevitable, and indeed many of the issues raised by the diplomates were being addressed in the new curriculum in each centre.

Perceptions Of The Course As A Preparation For Practice

Overall the diplomates viewed the course positively, suggesting it was the way forward for nursing. As one staff nurse in centre two commented:

> *"On the whole, and I can only speak for my group and a few others, the training has worked and people have felt the benefits, both staff and newly qualifieds from the training. (...) I have enjoyed the training. At first I did not but I got used to it and you get a lot of satisfaction."* [251621/2/33]

Another reflected that the style of the course suited her much better than the traditional course:

> *"I went into the course knowing that it was giving me the right balance between the academic side and the clinical side. I couldn't have gone on to a course where I was just thrown straight into a ward and told to get on with it, sink or swim. I work for a week, went back into college for a couple of days, and then I was back out again - I couldn't have done that. I need to know why I am doing this, rather than just doing them and copying somebody else."* [111634/18]

Questionnaire respondents were asked to reflect on the course as a whole and to suggest the overall strengths and weaknesses of the course (Q098). Table 43 presents these findings:

Table 43: Q098 Strengths and weaknesses of the Project 2000 course

	Centre 1		Centre 2		Both	
Category	*n*	%	*n*	%	*n*	%
Strengths						
Academic base/credit	24	47%	10	43%	34	46%
Questioning/analytic	15	29%	3	13%	18	24%
Communication skills	13	25%	4	17%	17	23%
Research base	10	20%	11	48%	21	28%
Assertive/challenge/ confident	9	18%	3	13%	12	16%
Supernumerary Status	5	10%	3	13%	8	11%
Broad theoretical knowledge	3	6%	3	13%	6	8%
Holistic approach	1	2%	0	0%	1	1%
Health promotion	1	2%	2	9%	3	4%
Weaknesses						
Lack of practical skills	22	43%	9	39%	31	42%
Lack of ill health/A&P input	10	20%	9	39%	19	26%
Reality gap	4	8%	2	9%	6	8%
Disorganisation of course	2	4%	2	9%	4	5%
Poor teaching	2	4%	0	0%	2	3%
Lack of tutor support	1	2%	1	4%	2	3%
Student/worker conflict	0	0%	2	9%	2	3%
Too much self direction	0	0%	3	13%	3	4%
Other	9	18%	3	13%	12	16%
Total responses	131		67		193	
Total respondents	51		23		74	

Diplomates in both centres valued the academic base and credit offered by the course. Centre one in particular valued the questioning and analytic approach whilst centre two valued the research base. Diplomates in both centres felt the disadvantages of the course lay in the lack of preparation in practical skills, also lamenting the dearth of ill health input.

The questionnaire data provide an overview of the perceived preparedness of the diplomates (Q054), presented below as the four point scale responses (table 44):

Table 44: Q054 Project 2000 course provided appropriate preparation for work as a qualified nurse?

	Centre 1		Centre 2		Collapsed	
Category	*n*	%	*n*	%	*n*	%
Not prepared	11	24%	7	28%	18	25%
Prepared	35	76%	18	72%	53	75%
Total	46	100%	25	100%	71	100%

NB: 7 cases at Centre 1 were unable to answer the question

For those who suggested that the course had prepared them well, the most influential aspects of the course were the theoretical input, clinical placements, patient focused aspects and the 'new philosophy', e.g. holism, non-judgmental approach. For those who suggested the course had not prepared them for practice, they felt that the course organisation and content was lacking, particularly in the area of practical skills. Table 45 below illustrates the differences between centres:

Table 45: Q054 Influential and negative course aspects

	Centre 1		Centre 2		Both	
Category	*n*	%	*n*	%	*n*	%
Most influential						
Clinical placements	17	34%	6	27%	23	32%
Patient focused/new philosophy	11	22%	2	9%	13	18%
Theoretical input	9	18%	8	36%	17	24%
Good preparation/course organisation	7	14%	2	9%	9	13%
Able to challenge/question	6	12%	4	18%	10	14%
Prepared to continue learning	4	8%	1	5%	5	7%
Negative aspects						
Poor course organisation/content	15	30%	8	36%	23	32%
Lack of practical skills	12	24%	4	18%	16	22%
Other	9	18%	1	5%	10	14%
Total responses	90		36		126	
Total respondents	50		22		72	

When asked in the questionnaires whether Project 2000 nurses will initially find it more difficult to practice than traditionally trained nurses because the course is based on theory rather than on practical skills (Q078), 64% disagreed. Of those who commented further, the responses suggest that there is a feeling of competence, little different to traditional nurses (23% in centre 1 and 21% in centre 2). It was suggested that it may be initially difficult, but that this was soon rectified, and that the theoretical component of the course was valued for its ability to inform practice. For those agreeing with the statement, the lack of exposure to practice was cited (22% in centre 1 and 31% in centre 2) together with the resistance to change and the expectations of others. The practical skills identified as lacking by the diplomates included care on intra-venous infusions, stoma care, naso-gastric tubes and catheters.

At interview, the staff nurses were also able to identify gaps in their knowledge, together with strengths of the Project 2000 course. In reflecting upon the course as a whole and the adequacy of it as a preparation for the staff nurse role, some at interview, suggested that the course could not really prepare students for the transition to staff nurse. One diplomate commented:

> *"They do try and prepare you for it [transition] but I do not think there was anything that could prepare you for that feeling of just hanging out there on your own. (...) I*

> *do not think there is anything they could really do.(..) It is like the first time you swim, isn't it? "* [261609/1/8]

A common criticism of the course, has been the lack of practical skills with which the diplomates emerge. This was shared by one of the staff nurses interviewed in centre 2:

> *"R: Thinking back over the Project 2000 course, do you think it was adequate preparation? Do you think you were well prepared to be a qualified nurse?*
> *P: Not on the practical. I said it all throughout the course that there was not enough practical. We did a lot of theory but I do not think we did enough on the practical side. I do not know how you can address that."* [261610/2/12]

This was a view common to the staff nurses in centre one, who also commented that they had been in college too long at the beginning before 'hitting' practice (after four months). As one staff nurse reflected:

> *"We had 15 weeks of theory at the beginning where you did not go near a patient, and that was far too long. It was too much too soon. There were people who, after those 15 weeks, discovered that that was fine but they did not like the patient end of things. The smell of the ward made them sick! It is a bit late after three months into it to discover that you do not really like the job."* [111623/9]

For the majority this was an initial issue only, as any deficits in this area were quickly made up. It was seen by the diplomates in this study to be a tall order to expect the course to fully prepare for every aspect of their role, and they took the pragmatic view that it was an impossible task. This was further illustrated by the idea that learning about the staff nurse role really only began upon qualification. One staff nurse who had been qualified eleven months commented:

> *"I wouldn't put the course down in any way at all. It has prepared me pretty well knowledge-wise. I still think that your great bulk of experience is actually going to come from when you're actually working in the ward itself, in the situations as they arise."* [251630/2/11]

The course was consistently identified as an excellent theoretical preparation, and the staff nurses felt that they had the knowledge and rationale behind practice. The diplomates were well versed in research and were keen to continue their learning, by undertaking further courses. One staff nurse reflected that despite this there will always be challenges for newly qualified staff, and this would be as true for Project 2000 diplomates as their pre-Project 2000 colleagues. However some felt that they had been ill-prepared for certain aspects of the staff nurse role, most commonly ward management was included in this.

Management Preparation - A Hit & Miss Affair

The theoretical management preparation of the course was thought to be good, but help was needed initially in the more practical aspects. For example in ward management; the prioritising; decision-making; organising the workload and delegation to others. As one staff nurse commented:

> *"So in one respect I feel the course - the Project 2000 training is wonderful. It teaches you management that the traditional course didn't, because I can tell you I can talk from experience because I have done both. You do management studies and you do team building and you do motivation and goodness knows what. That is fine. (...) But when you are a junior D-grade you are not expected to motivate a team. All you're expected to do is to make sure that 16 patients are washed and fed and dressed by the time the late shift comes on, and if they're not and there is only three washes done, explain why not."* [251620/2/13]

The variation of practice experiences meant that the course was often very 'hit and miss'. This was particularly evident in the management skills practice, where there was no standardisation and students on different wards were having very different experiences. In centre one a staff nurse suggested:

> *"I am in favour of Project 2000; I am, and I think I have put that across in the questionnaire, but one of the major criticisms I would say is that you don't get much management experience at all. I think it is very individualised. You can have one person on the course who will have got more management experience than I did, possibly because they were a bit more assertive and a bit more outgoing, and their mentor in the third year noticed that and thought 'Right, I'll give you some management'. There isn't any set criterion 'You must have this'. It's between the mentor and the student, and because I was quite shy and a bit frightened and shied away from doing any management, I managed to get out of it - but that was to my detriment later on, wasn't it?"* [121622/4]

In centre two it appeared to be a similar situation. A staff nurse who had been qualified seven months noted:

> *"I would make sure that the management unit was better (...) because it is totally up to the ward how they run the management unit and so some people were managing whole wards or, in the case of wards like this, they might have been managing half the ward; and other people like me - I was doing a bay and people were not even aware of what I was doing. Certainly if you got a better management experience it would be easier to make the transition to staff nurse."* [261617/2/16]

The participants in this study in both study centres found the lack of standardisation in the management preparation unhelpful.

Perceived Strengths of the Project 2000 Course

Those interviewed were able to comment on certain principles of nursing within their own philosophy that they felt had been fostered by the Project 2000 course. Some of these have been identified in section 2, and these include an awareness of the importance of both research and holism, together with a sense of professionalism. Being an advocate for patients and putting patients first was felt to have been fostered by the course:

> *"I can only talk about myself and my friends. I've got a lot of friends who are very good nurses. I don't think they would have been as good is they had not done Project 2000. They are very - it gets back to being patient-orientated again - they are very patient-orientated, and if they don't believe that what a doctor is saying is for the benefit of the patient they will turn round and say. I think that can only be a good thing".* [111634/11]

> *"I personally learned from the very beginning when I started my training that I'm there for the patients, not for the staff."* [121634/8]

The questionnaire data present an overall picture of the specific academic areas valued by diplomates, in responses to the question "which of the subject areas in the curriculum have been the greatest help to you in the practice area?" (Q024). As shown in table 46, life sciences, inter-personal skills (IPS), research, and psychology all featured strongly to varying degrees in each centre.

Table 46: Q024 Subjects of greatest help

	Centre 1		Centre 2		Both	
Category	*n*	%	*n*	%	*n*	%
Inter-personal skills	26	49%	6	26%	32	42%
Practical skills	18	34%	2	9%	20	26%
Life Sciences	18	34%	7	30%	25	33%
Psychology	14	26%	6	26%	20	26%
Sociology	13	25%	3	13%	16	21%
Research	12	23%	7	30%	19	25%
Nursing theory	5	9%	2	9%	7	9%
Drugs/medicine	5	9%	1	4%	6	8%
Ill health/disease	4	8%	6	26%	10	13%
Nursing ethics	4	8%	1	4%	5	7%
Management	2	4%	6	26%	8	11%
Branch knowledge	1	2%	0	0%	1	1%
Health education/promotion	0	0%	2	9%	2	3%
Personal development	0	0%	1	4%	1	1%
None	10	19%	4	17%	14	18%
All	4	8%	0	0%	4	5%
Total responses	136		54		190	
Total respondents	53		23		76	

It can be seen from table 46 that respondents from centre two appeared to value research, ill health knowledge, and management more than those in centre one, who placed greater emphasis on practical skills.

Perceived Limitations Of The Course

At interview, there were also many criticisms of the Project 2000 course. These largely revolved around course organisation, and levels and standards. Some respondents suggested that there often appeared to be lectures for the sake of them to fill in timetable gaps. The course was repetitive, and some lectures in particular came in for heavy criticism in this regard. The following comment from a staff nurse in centre two reflects the views of many of her peers:

> *"We missed at least a third of our course by missed lectures mostly, ...(with) the lecturers not turning up. (...) And when we got the lectures sometimes they were repeats of the ones that we had had before, and you are like 'Oh my God, we are having a lecture but it's a repeat of what we've had before!' Other times they were just for the sake of them. It really seemed like that there was no basis. You could not say yes, when I go into my nursing that is going to be helpful to me. It just seemed that it was for the sake of it because we were doing a diploma and we would have this lecture, and no thought had gone into where it would fit..) It was just very badly organised, very badly run."* [261617/2/11]

It was the same in centre one with students complaining of a disorganised course and much time wasting. One diplomate commented:

> *"The actual trying to survive Project 2000. It was actually trying to survive it - the idea that the college just did not know what it was doing most of the time. It was completely lost. And again, that went with nursing. It is very similar - the illusion. Compared to a university course, it was just a shambles. A lot of the people did not turn up for lectures, as in tutors."* [122667/26]

The standards of teaching came in for some criticism in both centre one and centre two, both for the teaching abilities of the lecturers, and for their limited knowledge of the subjects needed for the Project 2000 course. One staff nurse in centre two had noticed a distinct theory practice gap:

> *"I don't think the course was as good as it should have been. (...) They were still telling students things that they had practised as tutors when they were students or qualified, but it has changed. They tell you that in practice you do this and you do this, but you don't. It's different."* [251608/1/3]

However from the questionnaire data it would appear that the gap also existed the other way around. In response to the question "From your recent experience in practice do you think a 'gap' exists between the nursing theory you have explored and the practice of nursing that you have experienced?" (Q079) 81% agreed that a gap existed. The reasons given for this reflected the practice environment not having kept pace with the recent changes in nurse education (resistance to change), together with structural constraints such as poor staffing levels having an impact.

At interview another staff nurse from centre one felt that the level of teaching on the course was inadequate:

> *"There were quite a lot of us who said that you might be very good nurses but the standard of your lecturing just is not what you would get in a university, a poly or wherever, so do not kid yourselves that this is third-level education."* [111623/8]

Another commented on the teachers' poor understanding of the philosophy of the course:

> *"they are trying to teach a philosophy that is not really, I don't think, what Project 2000 is about, that you are managers when you go on the wards and then people think that once they have done a bed bath that's it with that low level of nursing, and they do not understand that there is a great deal of contact with the patient, building up a relationship. I think people from the school of nursing should certainly be a bit more aware of what the philosophy of Project 2000 is if they are going to give a proper view to a student rather than saying you are going to be managers and that is what Project 2000 is all about (...) I think for Project 2000 you need a far more dynamic system and you need tutors that understand what the philosophy is about,(..) I think it needs people who have been trained specifically and who have passed teaching qualifications to be teaching Project 2000 students, not people who have just gone in there as a move from nursing."* [261617/2/13]

One diplomate in centre one felt that it was vital that nurse teachers were enthusiastic about Project 2000 and reflected:

> *"I think we were very lucky - when I did Project 2000 we had a group of tutors who were very committed to Project 2000, who were very interested, who were very enthusiastic about their job, and that rubbed off, which is good. I shared a flat with another girl who was a few intakes behind me; she's qualifying next year sometime and she had a bunch of tutors who right at the very beginning told them that they did not agree with all this Project 2000 rubbish but they would teach them anyway, and that is not the right foot to get off on! You are on a downward slide from the beginning, and it is no wonder it has been a battle all the way through for her on the course. I enjoyed the course in the main, all the way through, and I think it was partly because of the attitude of the staff."* [111634/23]

Another diplomate felt that one of the most important aspects of the course was the attempt to challenge and question some established attitudes, e.g. racism, but that this had not gone far enough. The mental health branch staff nurses felt that whilst some aspects of the Common Foundation programme were of value it was too adult biased and too long. Reducing the Common Foundation Programme to one year was felt to be a good compromise. The questionnaire data (Q025) suggest that particularly in centre 1 (16% of responses) there was repetition in the course, and responses in both centres suggest that life sciences and practical skills/clinical procedures were required in greater depth. Psychology and sociology were felt to have been covered in too much depth in both centres, whilst 13% of responses in centre two suggest that no subjects were covered in too much depth and that the course was superficial (Q026). At interview, those who identified problems with the structure and teaching of the course, often felt that they had been left to get on with it themselves.

There were mixed feelings about the extent of self-directed learning in the course, with some feeling that they had not been supported sufficiently by the college, and others feeling that it was up to you as an individual to get as much out of the course as possible. As a staff nurse from centre one commented:

> *"I think it depends on what you put in as to what you get out. Maybe that is why a lot of people don't do very well, you know. They don't realise it is not a course where you are spoon-fed. You have got to do some of the work yourself."* [111634/12]

Indeed these attitudes were not mutually exclusive. Those who felt the course had been lacking in certain areas as described above felt:

> *"at the end of three years that the only learning I had done was stuff that I had done myself.(...) this student-led learning - you basically learn it yourself. I know that there is this great big thing in the whole of education that students should be learning themselves, but it was not facilitated over at the school of nursing, it was just sort of knocked out for all the tutors that were doing their degrees at the time, I think. It was an easy way out ."* [261617/2/15]

Another diplomate similarly described it as unfair that *"Basically we were just left to ourselves"*. However, many agreed with the principle of 'making the most of the course', and described examples of seizing learning opportunities, particularly in the practice setting, which they felt enabled them to feel more confident on qualification:

> *"The practical skills covered the basics; they covered your blood pressure and that sort of thing, but a lot of them you were expected to pick up on the ward anyway, and you did. If you said 'Yes, I will have a go' you did pick them up. If you stepped back and said 'No, no; maybe next time', then you never got to do them. But that was the student's fault; it wasn't college's fault and it wasn't the ward's fault. If you are given the opportunity to do something you should do it and worry about whether you can do it later or not; you have got somebody there with you all the time, taking you through it, so you may as well have a go. That is how I learned a lot of what I did."* [111634/21]

The Contribution Made By The Course Towards The Process Of Socialisation Into The Professional Role

Respondents were asked in the questionnaires and at interview whether they perceived any difference between themselves and their 'traditional' counterparts (Q044). These data are presented here as further evidence towards meeting aim five: the contribution of the course towards the process of socialisation into the professional role. For some staff nurses it appeared to be difficult to compare themselves with colleagues, and their reluctance to explore this may lie in their understandable loyalty to their work mates. It is also interesting to note that others placed their responses firmly in the context of changes taking place within nursing and the NHS.

Different To 'Traditionally' Trained Nurses?

The questionnaire data provide an initial overview of this. Respondents were asked "As a qualified nurse to what extent, if at all, do you see yourself as different to non-Project 2000 trained nurses?" (Q044). Responses to the four point scales are presented below (table 47), indicating a difference between centres:

Table 47: Q044 Perceive selves as different to traditionally trained nurses?

	Centre 1		Centre 2		Collapsed	
Category	*n*	%	*n*	%	*n*	%
Not different	31	60%	12	48%	43	56%
Different	21	40%	13	52%	34	44%
Total	52	100%	25	100%	77	100%

The responses from the comments section of this question also indicate that those in centre 1 felt less different than those in centre 2, though in both centres, the 'thirst for change' category was the most popular response. That is research awareness and a questioning approach with rationale for actions was perceived as the major difference between themselves and their colleagues. See table 48 below:

Table 48: Q044 Differences between Project 2000 and traditionally trained nurses

	Centre 1		Centre 2		Both	
Category	*n*	%	*n*	%	*n*	%
Thirst for change	16	31%	12	50%	28	37%
The same	15	29%	5	21%	20	27%
More training/academic input	12	24%	11	46%	23	31%
Less practical experience	11	22%	6	25%	17	23%
Different approach to patient care	10	20%	1	4%	11	15%
Broader knowledge base	5	10%	2	8%	7	9%
Health education/promotion emphasis	2	4%	0	0%	2	3%
Contribute less to service demands	1	2%	0	0%	1	1%
Seen as different/stigmatised	1	2%	1	4%	2	3%
More management skills	0	0%	1	4%	1	1%
Other	9	18%	2	8%	11	15%
Total responses	82		41		123	
Total respondents	51		24		75	

No differences

At interview, as in the questionnaire data, some staff nurses did not perceive a difference between themselves and their pre-Project 2000 colleagues, or they believed others would not perceive any difference. One staff nurse put this into the context of her practice environment which she described as up to date:

> *"I don't think my practice is any more research-based than anybody else's. Perhaps that is because the ward I am working on has kept up with things that have come from the school of nursing."* [252623/2/20]

Many felt that patients would not be able to perceive any noticeable difference in practice between those who had trained on the Project 2000 and 'traditional' courses. Thinking of how colleagues on the ward might view them, prompted one diplomate to comment:

> *"I don't think they would really think of us any different to like another qualified that didn't do Project 2000.... I don't really think they would. Perhaps at first they might have been a bit threatened when Project 2000 first started, but I think they've got used to it now, and I don't think the fact that you've got a diploma makes that much difference to how they feel about you. A lot of them are doing their own various other courses. Probably that helps because it has helped them academically because they do these courses, and they think otherwise they will be left behind."* [261621/2/23]

That others were involved in updating, were undertaking their diplomas and degrees was mentioned by many of those interviewed, and whilst this was reducing any major differences between them, there still remained some areas of philosophy or practice that were perceived as 'different'.

Differences

Some staff nurses felt that they had a greater theoretical knowledge base than their colleagues, which enabled an analytical approach to care. A staff nurse in the intensive care unit in centre two had previously undertaken two years of a traditional course, and she felt that on the Project 2000 course:

> *"you were examined on a wider knowledge base that you could use in relation to what you are doing. That is a good thing. It has to be a good thing, because the more knowledge, as far as I am concerned, the better. The more knowledge you have then the more you appreciate what's going on, the more you are an effective person. (...) Project 2000, I believe, teaches you to be analytical. It teaches you to think and to reason. Some people do that anyway, but it teaches you to do it in a way that you can practice as a nurse effectively - or it should do. This is how I perceive the course."* [251620/2/28]

However, another staff nurse reflected that whilst the knowledge base may be different, all nurses were integrating, as others were utilising more research:

> *"there might be a difference if you've got a diploma and a traditional trained nurse together, but maybe the knowledge base might be slightly different. (...) maybe if you sat us down together to discuss care that maybe the differences would come out. I don't know whether the idea of Project 2000 was to make us look and act differently as well, because I certainly don't think that's what happening. We're all integrating together now as well, because of a lot of the traditional nurses are very much aware of the impact of research on current practice, and they are actually using that as well."* [251630/2/33]

She went onto say that whilst other nurses used her as a resource for research knowledge, the Post-Registration Education Project (PREP) meant that any differences in knowledge was reducing.

Other perceived differences included a broader view of nursing, more awareness of health and health promotion, and research. Another staff nurse who had previously undertaken 14 months of a traditional course commented:

> *"it is very different. You are looking at the healthy person which we did in Project 2000, which was a totally unique concept to me because before we had looked at disease processes. So that was quite good that they took it from the other way round. And also health promotion, health education - that was not particularly tackled on the other course. And research - I remember getting- we had a lesson on the traditional course and we had to get a piece of research and put it down, do a critical analysis, and that was it. I have still got the critical analysis, it was so basic."* [261617/2/11]

One staff nurse felt that the course had equipped her with a greater understanding of the community, and that as a result she felt better equipped to pass on her professional knowledge to community staff than her colleagues did. Another recognised that she was more assertive than some colleagues and was particularly prepared to be an advocate for patients:

> *"Oh yes, definitely, definitely more assertive, (..) sometimes when you first qualify you are very frightened to speak out, because you're the new kid on the block so to speak. But I would stand up tomorrow if I thought something was wrong; I'd say 'Look, do you feel that this is what you should be doing?' (...) and I think that is probably a lot more from the training."* [251630/2/34]

However not all the perceived differences could be said to be positive for the diplomates. One staff nurse felt that she had less confidence than her colleagues, exemplifying the initial skills deficit outlined above. For others any differences identified tended to be qualified as already seen, by an assertion that colleagues are up-dating and improving their knowledge too. One staff nurse described how the 'great big gap' that she'd expected was not in evidence in her practice area:

> *"But even the nurses that have been qualified a long time, they do know all the research now -there are always notices coming round about various things. I think they do tend to read them all. They take the Nursing Times or the Standard or something, and I think they do keep in touch. I originally thought there was going to be this great big gap, you know? I thought 'We will know everything and they won't know anything', but there's not"* [261621/2/15]

However, some colleagues found it difficult to welcome the Project 2000 practitioner into the practice team, whilst others were supportive.

Confidence: A Contradiction: Feeling Confident versus Feeling Like a 'Lemon'

On a broad level it would appear from the questionnaires and interviews as a whole that the diplomates possessed a degree of confidence unseen in some of their traditional diplomate colleagues. This is supported by the work of Jowett et al (1994) and Maben (1995). Unlike those interviewed by Gerrish (1986) they recognise their own limitations from the start, and recognise that they cannot and do not know everything despite the expectations of others. This would seem to suggest a high level of confidence. They are very knowledgeable theoretically and this seems to have had the effect of further highlighting any gaps in their knowledge. That is they are more aware of what they don't know. This has engendered an attitude towards knowledge and confidence previously unseen. That is they are more prepared to reveal to others their lack of knowledge and lack of confidence, which is described here as 'No Bluffing'. A staff nurse working on a mental health acute ward suggested that it was vital to ask for help, and that was something that the course had instilled in her:

> *"P: What is important - it is always important - is that if you do not feel you can do it, then just go to someone more experienced. You must do that at all times and if*

> *you can do that, there is no problem. There is normally always someone who can show you.*
> ***R:** I know you cannot speak for everybody, but do you think generally that people who have come through the course feel that it is OK to do that, to go and ask and say they do not know how to do something?*
> ***P:** I should hope so, because it is very dangerous if you do not do that. I feel that I can but maybe that is due to the staff I have around me. (..) That was something which was stressed during the training anyway - if you do not feel able to do something, do not do it; get someone to show you how to do it."* [252623/2/16]

However, feeling lost or 'like a lemon' initially in the clinical environment was also a factor common to the new staff nurses interviewed, and indicated an initial, specific lack of confidence in their own abilities and skills. This was often the result of unfamiliarity with the particular area in which they were working, for example, having nursed mainly medical patients during their education, and now finding themselves with a staff nurse post on a surgical ward. Some felt initially unsure about their level of knowledge, and a degree of role confusion fuelled this uncertainty. The same staff nurse commented:

> *"I was thinking, 'what am I supposed to do with this person?' Trying to work through their problems, I was thinking, 'Have I really got a clue what I am talking about? Do I actually know anything? What am I talking about? Am I just bull-shitting?' That was what was going through my mind. It was not until I had been qualified for five to six months did I just jump into individual sessions and feel confident that I was going in the right direction and that I was doing something of any value for the patient."* [252623/2/1-12]

Without exception however this lack of confidence was short-lived, and for all diplomates it had disappeared certainly by six months and for many by 2-3 months. As one diplomate commented:

> *"Soon you get into it and you know what to expect and you know what to do when patients are admitted and when they are discharged (...) Now I feel much better because you just learn so much from being on the ward all the time. But certainly when I first qualified I felt really unhappy and I felt my God, I can't do this, because I just did not know what I was doing basically (....) It took about a month, I would say, to start settling down a bit more and feeling a bit better, but it took about three months to really feel confident in the position."* [261617/2/4]

Not having to ask for as much help appeared to indicate a rites of passage or a recognition that perhaps transition had been achieved, rather like the 'metamorphosis' described by Gerrish (1986). A staff nurse working on an elderly rehabilitation ward reflected:

> *"I definitely feel I've developed a hell of a lot more since qualifying, and I'm now both very confident and I feel quite competent at what I'm doing as well, and I know that if I know what my limitations are I can go and ask for help - say 'Look I'm really not sure about doing this, but can you guide me through this?'. I very, very rarely have to ask for that help any more, because they're quite happy with the way I've*

> *evolved, and they're quite happy to let me go and do things on my own - well, after three or four months it was like that."* [251630/7]

The general confidence instilled in the diplomates which enabled them to question others and ask for help, was not always in evidence in all areas of their work. It was often those aspects of their role which appeared to differ most significantly with their roles as students which predictably caused the most significant difficulties in the first few weeks and months after qualification.

Section Summary

In summary there were mixed feelings about the course, with some feeling well prepared to commence their first staff nurse post, whilst others felt initially ill-prepared, particularly in 'practical skills'. This was however identified as an initial skills deficit only and it was seen as a tall order to expect the course to prepare them for every aspect of their role. Indeed some took the pragmatic view that this was an impossible task. The course was perceived to have fostered an awareness of research and holism together with a sense of professionalism. Advocacy and putting patients first was also identified as a legacy of the course. Certain aspects of the course were consistently identified as needing attention, and these included the management preparation which was described as inconsistent and haphazard. The course was also described as repetitive, poorly organised and teaching standards were criticised. Self directed learning was perceived as 'lack of support', although others suggested that it was up to each individual to get the most out of the course as possible.

Diplomates who perceived themselves as different to traditionally trained nurses cited a greater theoretical knowledge base and a broader view of nursing which included an awareness of research and health promotion. Others felt there was little or no difference between themselves and traditionally trained nurses, and suggested colleagues were involved in updating and undertaking further study thus reducing any major differences between them.

The issue of confidence has been highlighted and the inherent paradox of this has been presented. On the one hand the diplomates appear more confident and assertive and are prepared to ask when they don't know something ('No bluffing'). On the other hand however, and perhaps because of this, they appear more uncertain and to lack initial confidence in the clinical area. This was however short-lived and for all diplomates had disappeared by six months post qualification.

4. 5. NEW ROLES AND RESPONSIBILITIES: THE NEED FOR PRECEPTORSHIP AND SUPPORT

A key issue emerged from the data on the perceptions of the newly qualified nurses. It is apparent that this group had encountered many new responsibilities. It was equally apparent that their needs for support and preceptorship during the transition period were rarely met.

"You're On Your Own": Issues of Responsibility and Accountability

The feeling of greater responsibility was encountered by all, and this was often described as the most marked difference between being a student and a staff nurse. In particular other people responded differently to a qualified nurse, than to a student nurse. One staff nurse described this change as from 'a visitor to a member of staff', and felt that this helped her to be taken seriously by others. Staff nurses were given more respect in line with the increased status that the new uniform bestowed. A staff nurse described her first few days as:

> *"Nerve-racking, very worrying. You are a real nurse and you can't hide behind your check blue uniform [laughs]. Yes, you have got responsibilities and you are looked upon as a staff nurse. It doesn't matter - people don't know that you have just qualified. "* [261618/1/2]

A sense of 'being alone' emerged, whereby staff nurses were no longer 'cushioned' by senior colleagues and could not 'pass the buck' to a mentor, or tutor, as they could when a student, which is illustrated by the following extracts :

> *"It was just knowing that, as a student, you could always say, 'I feel a bit out of my depth here, could you give me a hand, or could you come and sort something out for me?', whereas I could not because the buck stopped and that was it!"* [251621/2/8]

This feeling of being 'on your own' was most evident when staff nurses were administering drugs. As a student this had always been undertaken with a qualified nurse, but suddenly as a staff nurse medication was given entirely alone. The responsibility for administering drugs alone was indeed a recent development in nursing that many of their 'traditional' colleagues would not have had to face upon qualification. One staff nurse reflecting on this experience commented:

> *"P: A drug round for 18 patients took me an hour and a half!*
> *R: Did you do it on your own?*
> *P: Yes, I did, but with the B.N.F. (British National Formulary). I was scared. I think that was the worst bit actually, the drugs, doing them on your own. You have got some dangerous drugs and doing the controlled drugs with a student, say a third-year student, that was scary as well. Now I look back, I was frightened. "* [261618/2/4]

Implicit in the concerns expressed about drug administration was the increased accountability that qualification brought. Indeed accountability, and the avoidance of mistakes in practice was very worrying to the new diplomates. The increased threat of litigation was consistently identified and this resulted in extreme caution.

The management of, and responsibility for others in the nursing team was also an identifiable difference from their student days, and a cause of anxiety, exemplified in the following extract:

> *"When I went on to the ward, (..) I was put in charge of 16 patients, and these two HCAs said to me 'What do you want us to do?'. I stood there thinking 'What do I say?', when two weeks ago a staff nurse was saying to me 'Will you go and wash that patient and I will wash that patient'. Now all of a sudden it is me that has come to decide who needs what. (..) You are making decisions and people are following your decisions, (..) It was a hard thing to come to terms with.(..) All of a sudden I am thinking for four people; I am thinking for me, the two HCAs and this poor patient who is waiting for me to do something."* [251620/2/9-10]

Lack of immediate support and someone to call on, a hectic busy ward with few experienced staff and general staff shortages was a recipe for a difficult initiation into the role of the qualified nurse.

> *"To be left in charge of 16 patients after you have just qualified is a really frightening experience, especially when they are acute medical and there are a lot of technical things, like pumps going off left, right and centre. Not having somebody there, say a more experienced D-grade or an E-grade, who could sort those things out or show me, was very difficult."* [251621/2/5]

Several staff nurses described being 'thrown in at the deep end', and this was often felt more acutely on night duty. A staff nurse in centre one described her early experiences as a qualified nurse:

> *"I found it very difficult the first three months or so. I found that I was very much in at the deep end with things like, for example, I started on seven night shifts (...) there was only the two of us on a night shift on the ward. And I found that going even from the nurse bank into that was quite heavy going, because I had a lot of post- ops the night I started. In the morning doing the medicine round and things like that which I had never done, and I was doing that by myself out of pure necessity."* [111608/2]

However the staff nurses learned to cope with this aspect of their role, and suggested that this happened within the first few months after qualification. Being 'left in charge' of the ward was often a significant turning point, and having coped and got through the shift with no major mishaps was a relief and gave increased confidence. In fact responsibility was sometimes seen as a two-edged sword having both difficult and satisfying aspects. Whilst responsibility was often an initial difficulty, it could also be transformed into a positive aspect of the role some months after qualification.

Preceptorship And Support: Myths And Realities

The environment in which the diplomates commenced their qualified working lives was crucial to a smooth transition, even for those who felt well prepared upon qualifying. The lack of support experienced by the majority of the newly qualified staff nurses is evident from the experiences of being 'on your own' described above. More specifically the attempt to provide support and preceptorship for the new diplomates is demonstrated further in this section. A period of preceptorship has been recommended for all newly qualified staff nurses (UKCC 1993). One of the main purposes of this is to help provide 'a smooth transition from learner to accountable practitioner' (Morton-Cooper & Palmer 1993:99). In this study it would appear that its implementation is far from realised, and there exists a degree of 'lip service' currently being paid to it as a concept.

For example of the ten new diplomates interviewed in centre two only five had received some type of support or preceptorship in their first post, but of these only two had really received a comprehensive detailed supportive programme for any length of time. These two had an identified mentor for six months, and whilst one had a planned programme with objectives and learning outcomes, the other had an informal less structured experience. The nurse who had experienced the more formalised planned preceptorship reflected:

> *" I had this wonderful preceptor, (....) She was great and she showed me round. (....) She cushioned me for an awful lot of things (..) and for the first couple of shifts I actually worked with her completely for the whole shift as an extra, like a supernumerary again, which was nice. (..) We set out some objectives in the first week what I wanted to do and probably about a month into it, we had achieved all of them. She taught me how to take blood, which we do here, and things like that. She was just there like a tutor if I needed her but she was better in some ways, because you did not feel like you would be bugging her if you asked her anything and she is so nice anyway and very approachable."* [261609/1/2]

In centre one, again only two had received a comprehensive preceptorship, one was in a generally very supportive environment, three had no preceptorship at all and four had very limited preceptorship whereby it was not taken seriously or it commenced, and then 'fizzled out'. This poor implementation or indeed paying lip-service to the notion was an attitude encountered by many. In centre two a staff nurse reflected:

> *"I don't think the preceptorship is being taken seriously at all. There was no sort of - as regards my key worker, she would just say are you going on alright and I would say yes. I was doing all right and that was about it. There was not anything structured or planned.(....) I don't know, there certainly was not preceptorship; it was just a sort of title bandied about which nobody really took seriously."* [261617/2/3]

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And in centre one the experience was similar. One staff nurse commented on the poor organisation of her preceptorship programme:

> *"It hadn't been that organised because my preceptor is actually doing an MA in counselling as well, so she tends to do 12-hour shifts, so I can miss her quite easily, which I have done for about the past three/four months."* [111608/3]

Without exception, all of those interviewed, whether or not they had experienced it in practice felt that it was an excellent idea, and was or would have been helpful to them. In centre one a staff nurse who had been promised preceptorship, but subsequently found that it never materialised reflected on how useful she felt it would have been:

> *"I was told at the interview that I would have some preceptorship and that the sister would be my preceptor, and I haven't had any whatsoever. I haven't - I think I've had 'How are you getting on?' and 'You're doing fine' and 'We're really pleased, you've got stuck in there and you're doing this, that and the other'. Nobody's ever sat down with me and said 'What do you want to achieve? Have you got any goals, outcomes?' that sort of thing. I find that very disappointing. (..) that time aside could have done so much - I could have sat down and said 'When I'm left in charge I've done this; is that all right?' instead of going home and worrying about it."* [121622/5]

Many of those who had not experienced any preceptorship also felt able to suggest in detail what they felt would have been helpful to them. A staff nurse in centre one on a haemodialysis unit commented that what she felt she needed was:

> *"Some way of turning round and being able to say 'I still don't know this, even though I'm qualified and I'm expected to know this, I still don't. Please tell me what I want to know. How do I inform doctors, and things - Really it's being treated like a student a little bit, but although you are now qualified and you are now taking responsibility for what you're doing, you still need, like - I don't know, a bit of shelter I suppose, from the full onslaught of patients coming at you at all angles and doctors coming at you at all angles now, because you're now the staff nurse. Before, it was quite easy when you're a student just to say 'Sorry, I'm just a student nurse, I'll just get one of the qualifieds for you', and that was it. Now it's - 'You're qualified, let's see the master at work' sort of thing."* [121625/19]

Another diplomate in centre one felt that a more structured rolling programme with a list of goals, and regular appraisal and feedback would have been beneficial. A staff nurse in ITU centre 1 reflected that whilst she felt that she experienced a good preceptorship, it was also the fact that the whole environment was so supportive which facilitated an easier transition to the staff nurse role:

> *"I must say that I felt very well supported but that is due to the unit more than to my preceptorship.(..) I had three months, [preceptorship] which is the minimum that this unit offers, working with a staff nurse who is quite well-qualified and has been here quite a while and has wide experience. Initially, it was a question for the first couple of weeks of totally observing. Then for the next couple of weeks, working with and then as the first month rolled into the second, actually taking the patient, taking*

> *responsibility for the patient, and by the third month actually taking a patient, just with somebody keeping an eye. Nevertheless, there was the eye there - it was not just get on with it.(..) It was well organised from the education side. There were lots of hand-outs, lots of teaching sessions. Anything going you were encouraged to go to. Whether it was for post-graduate or student nurses you were encouraged to go and have a look at it to see what was going on. That was quite good and well organised. (..) Also I suppose the particular mix of staff that we have ensures - we are quite a close group although we get on each other's nerves, but they are quite supportive. You would never be abandoned if you shouted "help". You would never be standing there - there would always be somebody sticking their nose in to see what it is going on, even at this stage, which is very nice. That goes for anybody. If you have been there for ten years, it is the same type of environment for them as well. In that sense, therefore, I feel quite well prepared for the job I am doing."* [11623/5-6]

Supported or Supporter?: A Paradox

The lack of support experienced by the diplomates was highlighted by a particular paradox. Some of those interviewed had been expected to provide support for others in their first few months, at a time when they were vulnerable and in need of support themselves. It was seen by the staff nurses as an impossible task to mentor students whilst they were attempting to come to terms with their own new role:

> *"So as soon as I qualified I was given a student, which I thought was ridiculous because you are getting used to the role yourself and then they are expecting you to assess students and do things like that."* [261617/2/3]

It was however the timing of the expected mentorship, and not the fact that the staff nurses were unable or unwilling to teach students. As with other difficulties described above, after a consolidation period these initial problems receded:

> *It is now, after just about 12 months, I have reached the stage now where I have gone through the transition; I have been busy being a staff nurse. I am a staff nurse, but I have gone through all the grief and the hassle, and I'm a bit more relaxed about my role. I'm better with students now. I have had students when I'd been qualified a month first qualified, (...) but (then) I was too busy learning to be a staff nurse.* [251620/2/14]

The Myth Of Continuing Education:

There was a commitment amongst all qualifiers to continuing education and lifelong learning which was evident from both the interview and questionnaire data. Respondents were asked their career intentions over the next two years at the end of the questionnaire (Q101). Over one quarter of the responses in centre two and 11% in centre one wanted to pursue a degree in nursing within the next two years. Interestingly all of those interviewed in centre 2 (except the staff nurse who already had a degree) intended to 'top up' to a degree, and several in centre one. Questionnaire respondents were also asked to indicate on four point scales the extent to which they wanted to continue to develop (Q073) and the extent to which they were able to continue their development (Q074). Ninety six per cent in centre 2 and 89% in centre 1 wanted to continue their development. However, only 50% in each centre felt able to continue their development. The factors that were identified as inhibiting development (Q077) could be placed under the banner of lack of resources. Indeed this was a reoccurring theme throughout much of the data, but it was particularly striking here. Staff nurses at interview described, the lack of funding for courses, the lack of study days, and the need to wait in a queue with colleagues to get any support with continuing education at all. Factors identified in the questionnaires as inhibiting development included lack of financial support, staff shortages, no study leave, negative staff attitudes, and inaccessibility to courses. Conversely, staff support and encouragement together with study leave were cited as crucial to the facilitation of the staff nurses' development (Q076).

The Supportive Environment - The Key Ingredient

In general those who had experienced a supportive environment, which may have included some type of preceptorship, found aspects of transition to the staff nurse role easier, and their confidence increased. A diplomate in centre two reflected:

> *"On the nursing side, after two or three months I started really to get confident in what I was doing. I am not a very nervous person and I just work my way through it but for the first couple of months I did not have any confidence in anything at all. X [Preceptor] helped with that a lot."* [261609/1/7]

Other environmental factors which helped included generally approachable and forward thinking, up to date staff who were willing to help and teach the new diplomates; being trusted by staff and given responsibility; receiving regular feedback on progress; and having a regular forum for discussion in the practice area. Several staff nurses interviewed had already changed practice areas since qualifying (See appendix 14 for more details), and the comparison of areas that this enabled, yielded some interesting data. One staff nurse who on her first ward felt staff had not treated her with respect, and had undermined her confidence, now felt the benefits of a more supportive environment:

> *"But going from that to going to this unit where people say to you 'Right, as you're a D-grade you get on with it', people say to me 'You wouldn't be here and you wouldn't be doing this job if we didn't think you could do it'. I've been there a couple of months now and I've been told that they are happy with what I'm doing. Nobody's told me off; if I've done something wrong I have been told quietly and calmly 'You did this wrong'. This is the right way to do it, not stand there and tear a strip off you, which I've seen some sisters do to staff nurses in the middle of the bay, which drives you up the wall. "* [251620/2/42]

Feedback was crucial for the new staff nurses, as identified by this staff nurse in centre one who had yet to receive any:

> *"It would be nice just re-evaluate yourself after six months as well, which I found that I haven't had any period of evaluation yet. I haven't really had anyone telling me how I've done as such either, which you could really do with. (..) I think that's one thing nursing lacks as well. You can't get any praise whatsoever. Not that I'm such an egomaniac that I want someone to say `Oh well you did that well', but just every now and then to say `Oh you handled that well' or `You really handled that very well with that patient' or `You could have done something differently there.' Just things like, but I don't think that ever gets said. The ward environment I think people tend to make remarks about each other, rather than using it constructively."* [11608/42]

Indeed the importance of feedback has long been recognised (Quinn 1980). The role of the ward sister or manager was also cited as a crucial factor, (supporting a wealth of earlier work in the area, e.g. Ogier 1981, Fretwell 1982) and a supportive, innovative sister helped the staff nurses settle in more quickly.

Section Summary

For the majority getting to grips with their new staff nurse role often meant dealing with new and different situations and issues than when they were students. The responsibility and accountability enshrined in the code of conduct (UKCC) had a big impact and was felt keenly by all:

> *"So it is really suddenly being in a position where you are managing patients and you are also responsible. That is the big change that took place between the student and staff nurse (....) when you qualify that people are asking you questions; doctors are coming up to you and you are having to delegate other people's work loads, and I personally had not done any of that before at all. That was a big surprise when I qualified."* [261617/2/16]

Diplomates often felt alone and unsupported which for some resulted in a difficult initiation into the role of qualified nurse. Some described being "thrown in at the deep end". The implementation of a comprehensive preceptorship programme had not been realised in this diplomate sample, with few having adequate support and guidance in the first instance. A degree of 'lip-service' to the notion of preceptorship was identified. Indeed the lack of support experienced by the diplomates was highlighted by a particular paradox. There was an expectation in some practice areas for the diplomates to mentor and support students when they themselves were still getting to grips with their own new roles. Those that experienced a more supportive environment, which may have included some type of preceptorship programme found their transition process easier. This environment fostered trust and respect amongst staff, often facilitated by a forward thinking dynamic ward sister in which regular feedback to the diplomate was both important and forthcoming. There was a commitment amongst the diplomates to continuing education and lifelong learning. However for many, a lack of resources was a significant factor inhibiting further development.

4. 6. THE QUALIFIERS' TALE: OVERALL SUMMARY

Within the questionnaires and at interview the staff nurses were able to articulate their philosophy of nursing. The central tenet of this philosophy was patient centredness, in which the patient was at all times the focus of any care given. 'Basic nursing care' was therefore highly valued by the diplomates who perceived it as an opportunity to assess, build relationships and pick up any cues or patient worries. The staff nurses also espoused an holistic broad ranging perception of their role and of nursing in general. This included an understanding of the wider determinants of health which, together with their desire to facilitate recovery in its broadest sense, may be perceived as health promotion. The staff nurses themselves did not articulate it as such however, preferring instead to understand that concept as relating more narrowly to individualistic lifestyle issues such as smoking, diet and exercise.

The diplomates were seen to value the theoretical knowledge of the course and research in particular, perceiving themselves as professionals. They believed their role in the multi-disciplinary team was crucial, and felt it was important to make their views known to colleagues. In this they were often determined patient advocates.

On the whole the course was seen to have prepared students well to take on the role of qualified nurse. The perceived course weaknesses included course disorganisation, lack of practical skills and a hit and miss management preparation. The self-directed learning philosophy had both supporters and critics, with some emphasising "you get out what you put in" whilst others felt unsupported. The strengths of the course included the theoretical base, and the questioning analytic, research based approach. These were also the areas in which there was a perceived difference between themselves and their non-Project 2000 colleagues. Many were however reluctant to perceive themselves as 'different', preferring instead to identify the progress and continual updating of colleagues.

Many diplomates had encountered some stigma and hostile reactions from colleagues, with the course coming in for considerable criticism. Some staff were perceived to feel threatened and to be resistant to any change in the practice environment. This was often problematic for the diplomates who had been socialised in to seeing their role as one of 'change-agent.'

The issue of the need for support emerged from the data as one worthy of comment. Preceptorship was seen to be poorly implemented, if at all in both study centres, with a degree of 'lip-service' being paid to it. The newly qualified staff nurses often felt unsupported in their new roles which was a source of some difficulty, given the increase in responsibility and accountability the new role bestowed. There was also a lack of support for the majority in continuing their education, with lack of funding curtailing this for all but the lucky few. Those who found themselves in a supportive environment were most fortunate, having access to more experienced colleagues, feedback, and a helpful ward sister.

Chapter 5:
Project 2000 and the Philosophy and Practice of Nursing: The Teachers', Nurse Managers' and Practitioners' Tale

INTRODUCTION

The findings presented in this chapter provide valuable insights into the perceptions and perspectives of three important sets of stakeholders. Focus group discussions were held with those holding clinical managerial responsibility (nurse managers), those taking ultimate day to day responsibility for clinical areas, (practitioners), and those in daily contact with Project 2000 students completing the diploma programme (nurse teachers). Demographic details of group participants are to be found in chapter 2 and appendices 20, 21 & 22.

Three main areas of interest were explored within the focus groups. The first concerned perceptions of the philosophy and practice of nursing. Nurse teachers in particular were asked to examine their own perceptions of nursing and to decide whether or not they had changed, developed or evolved since their involvement with the Project 2000 curriculum, or for any other reason. Their exploration then moved on to examine their views of students' perceptions of nursing and in particular which aspects were valued and whether these change as the course progresses. Complimentary data were collected from both senior nurse managers and practitioners regarding their perceptions of nursing and whether these had changed since the implementation of Project 2000.

The second topic for discussion revolved around the issue of whether the Project 2000 curriculum was an adequate preparation for students to take their place in post registered practice. Nurse teachers, mangers and practitioners were also invited to discuss the issues surrounding the concept of socialisation into the professional role. They were also asked to examine the question of who is seen to have the largest impact upon the student in terms of preparation for practice. These groups gave the managers and practitioners the opportunity to comment upon the course and reflect upon their perceptions of its ability to meet the changing demands placed upon nurses in the 1990's and beyond.

The third and final major area addressed was an exploration of managers and practitioners perceptions of the Project 2000 qualified nurse as a professional practitioner. The question was posed as to whether the Project 2000 'product' was producing what managers and practitioners wanted in the clinical area and whether the Project 2000 practitioner was perceived to affect practice.

Findings from the focus group interviews are presented in this chapter under three main headings which reflect these issues:

1. **Perceptions Of The Nature And Discipline Of Nursing**

2. **Project 2000 As A Preparation For Practice**

3. **Perceptions Of The Project 2000 Qualifier As A Professional Practitioner**

It is important to note here that positive procedures were laid down in the focus group data collection process to attempt to guard against any 'elite bias' as outlined in chapter two. That is the participants were asked if they felt the views expressed were representative of other colleagues views. In general this was perceived to be the case. Other threats to validity as identified in the focus group literature (Morgan 1988, Kitzinger 1994) were also addressed through clear opening instructions aimed at encouraging honest disclosure by participants (Macleod Clark et al 1996). Professional hierarchies within groups were avoided for this purpose and the groups were relatively homogenous (see chapter 2).

5. 1. PERCEPTIONS OF THE NATURE AND DISCIPLINE OF NURSING

Issues surrounding changes in the nature and discipline of nursing were explored in each of the focus groups. However, particular emphasis was placed on this topic in the teachers' focus group sessions to reflect one of the project's main objectives. Nurse teachers were asked to share their perceptions of nursing and challenged to assess whether these had changed, particularly since their involvement with Project 2000.

There was a general acceptance that their views had changed from the clear and perhaps narrow view they had held, previously derived from their own traditional training, to the more fluid and evolving perspective they held now. Control seemed an important issue which was now challenged and nursing was seen as more of an 'enabling process'. All the nurse teachers felt that their own education process had been a huge influence on their perceptions. In the last five years most of the nurse teachers had been involved in some type of education process themselves, as one teacher put it "the express train to education". This was also highlighted by the change in the coffee room discussions noted by a member of staff in their retirement speech in centre 1 (adult):

> *"Well ten years in the coffee room' - we used to talk about what was on the television and other things. Now it is a central action philosophy and a philosophical theory over lunch".* [p.13:S1/NT/13.7]

The post basic education that they had experienced resulted in an ability and desire to assess potential options and then choose the most appropriate action, rather than to follow the established norm, and then to encourage the students to take a similar approach. One nurse teacher in centre 2 (adult) stated how:

> *"In the early days of my career, I very much did what I did because it was the only way to do it, that has changed in me, I obviously try to develop that idea with the students. When they are dealing with a patient, there might be a menu of things they might do depending on the situation. That is quite a big shift for me. ...My traditional training made me very much black and white. My own post basic education challenged that."* [p.36:S2/NT/1.6]

The nurse teachers were asked whether they thought students' perceptions of nursing changed as their course progressed. There was a strong perception, particularly in centre two, that students evolved their own concepts of nursing as the course progressed. The nurse teachers felt that the students' perceptions of nursing moved from 'simplistic' notions of nursing being all about 'hands on care' in the initial stages of their education; to an expanded view incorporating issues such as accountability for practice and an appreciation of the breadth and scope of nursing. Initial interviewees were seen to have a very idealistic view of nursing, based purely on the notion of 'caring' for the patient, a very 'hands on' practical and narrow type of role. The majority of nurse teachers shared the view expressed by their colleague who taught on the common foundation programme, when he stated his surprise:

> *"about how many of them start off thinking that nursing is quite a simple business, that they are not going to have to do too much thinking. I do not think I am doing them a disservice. They are surprised by all this psychology, sociology, physiology, nursing theory etc."* [p.28:S2/NT/1.6]

Their view was perceived to begin to expand as they progressed in their education, gradually beginning to see the breadth of nursing as portrayed within the course. The issue of accountability and responsibility begins to be assimilated by the students. They were seen to slowly recognise that they need to be responsible and accountable for their actions, accepting the need for professional behaviour when dealing with all nursing activities. Nurse teachers within centre 2 felt that students in unit 5 (towards the end of the branch programme) had progressed in their own assessment of their needs and were beginning to acknowledge their need for management skills, requesting more supervised practice in managing a clinical environment. This highlights their progression within their course and reflects their evolving concepts of nursing.

The general changes perceived to have occurred in nursing focused around that of Trust status and the resulting conflict between issues of professional and organisational accountability. The tension between these two perspectives is seen to fall heavily upon the nurse managers. One nurse teacher (adult) from centre 2, felt they have been:

> *"trying for years to move away from the stereo-typed image of what a patient is and what we do with the patient. We are assessing unique situations and we are acting on them, and now they are being dictated to and they are having to go right back to that and that is causing them a lot of hurt and conflict."* [p.38:S2/NT/1.6]

Nurse teachers in centre 1 confirmed the above perception when they spoke about the students evolving perceptions of nursing. They seemed to concentrate upon the conflicts that they perceived students may have, rather than their concepts of nursing. The greatest conflict appeared to be created by the tension created when the culture of education met that of clinical practice. The dichotomy between being a student and the expectations of being a team member were seen to be problematic. The nurse teachers felt the student often fell in between. Within the common foundation programme (CFP) when the student would be 'supernumerary' the concepts of 'team work', 'professionalism' and 'others expectations' were seen to be lost upon the student. It was acknowledged that such understanding perhaps only began well into the branch programme. The nurse teachers did defend the student, recognising the dichotomy between treating them as students in college and expecting them to become 'members of the team' when in their clinical areas. The biggest point of change for the students perception of nursing was judged by the nurse teachers to be their first contact with the clinical areas, and for centre 1 that was after 18 weeks, as one teacher from the adult branch explains:

> *"They have this 18 weeks [in college], and we have people ... all fired up, willing and keen, and they have their own concept of what the whole idea of nursing is. Even just three weeks in the wards, they come back again [saying] this is what matters - it is almost as if there are two cultures, the educational culture, and what they want to see on the wards."* [p.18/19:S1/NT/13.7]

The Hospital - Community Interface

It appears that the biggest issue of change in nursing for nurse teachers particularly in centre 1 was the broader focus of nursing together with the idea of 'life beyond the hospital'. Their fear seemed to be how to support and prepare community staff for the implications that would follow from such policies as the Heathrow debate (D of H 1994). The emphasis has now moved away from purely concentrating upon treatment in hospital to assessing care beyond. This was articulated by one community nurse teacher who acknowledged:

> *"Now I hope nurses do think 'What are they going home to? What will happen to them when they go home? Who is there to look after them?' Not only their own carers but professional carers as well."* [p.4:S1/NT/13.7]

Nurse teachers in centre 1 accepted that their own views had 'broadened out' to involve the concept of giving care in the community, as well as that of hospital care, their traditional focus. But such a move to broaden their perspective was by some, seen to be at the expense of 'depth'. The necessity for the Project 2000 programme to emphasise community care went unchallenged. The major concern was around the provision of support and education for community staff themselves. A community nurse teacher in centre 1 stated how her:

> *"experience has been more towards preparing people in acute areas, and policies, the making of policies, that is not to say there should not be far more emphasis on community. For a teacher that worries me because I think what are we doing for teachers at this point in time to get this over to those in the community."* [p.5:S1/NT/13.7]

The Heathrow debate seemed to represent a significant concern for the nurse teachers in centre 1. The potential trend for some 60% of care to be given in the community, if the proposals within the report were adopted, was a concern. The need to be proactive in terms of placing nurse teachers in the community was acknowledged, whilst recognising that such pro-activity was yet to be established. There seemed a belief that the two institutions of community and hospital were still unable to liaise effectively and co-operate, with examples given where hospital staff were not acceptable in the community arena. The issue of community qualifications was voiced, recognising that for some community educated nurses there remained a reluctance to accept staff in the community without such a community background themselves.

The need to find solutions to such problems was clearly identified, particularly in light of the intended aims of the new Project 2000 flexible' practitioner. It was recognised that there was now a need to "break with tradition" and accept that the Project 2000 course was producing a "new type of being". There appeared to be a belief that learning disabilities and mental health perhaps fitted more easily into the hospital / community blend. Insecurity and threat also was recognised as a contributory factor in a rather more negative view shared by a mental health teacher:

> *"It would depend upon the structure and the policies. I remember the problem of education as a CPN. They introduced outreach workers, working from the wards to the community. The CPN's were unsure about that because they were going to take their jobs. It is very important factor."* [p.10:S1/NT/13.7]

There was a general conclusion in centre 1 that the 'flexible practitioner' had yet to truly evolve.

The issue of community and a changing environment of care also featured strongly in the managers and practitioners focus groups. When considering the future employment of Project 2000 qualifiers there was great concern from practitioners and managers in centre 1 concerning the potential role of the Project 2000 practitioner in the community. From their perspective it felt as though their link into the community remained ill defined. The managers did feel that 'theoretically' the Project 2000 education programme, with its emphasis on health as opposed to illness and upon community settings and the family as a whole, rather than the sick person, would have equipped people for the more health orientated service of the community rather than the traditional hospital setting. The practitioners from the same centre saw the emphasis on the community as now imbalanced to the detriment of the students' ability to learn the skills necessary for nursing hospitalised patients. With students now spending 22 weeks in the community initially, some felt that the nurse who chose to seek employment in a hospital setting would be disadvantaged by their lack of established experience in the clinical setting.

For the managers in centre 1 the main concern was in the area of health visiting, district nursing was seen to have adapted its service to the demands of skill mix reviews, employing staff nurses within their teams. However there was still considered to be a lot more work to be done in developing the Project 2000 diplomate nurses' role in the community. One dispute centred around the projected role for the child branch qualifier particularly if seen within the health visiting service.

The question posed concerned the issue of their ability to work within family assessment, having followed the child branch. It would appear that adult branch nurses were not as yet coming through into the health visiting service. There was an acceptance from the managers that nursery nurses are indeed a cheaper option in the community to do a lot of the work in assisting the health visitor in child care. The other view concerning the potential role for the child branch qualifiers was seen to be one of assistance in getting children out of hospital and back into the community, and continuing to nurse the 'sick child' in their own home. This service was not seen as part of any health visiting service but more related to district nursing, and as one child branch teacher describes:

> *"...I always saw them as being the buffer in a way to look after sick children in the community. "* [p.4-5:S1/M/5.10]

A debate was generated within the groups in an attempt to answer the question of why the Project 2000 qualified nurses were not apparently employed in the health visiting service. Lack of experience was not seen as the prime cause, although it was recognised that traditionally community posts attracted the more experienced nurses, and the Project 2000 qualifiers may find it hard to compete. The more pressing need was seen as providing a pathway for Project 2000 qualifiers to 'support' rather than replace the health visitor in her community role. The dilemma appeared to be how to integrate the newly qualified Project 2000 nurse into the service at the grade of staff nurse, offering them community experience at that level whilst supporting the health visiting role.

The practitioners acknowledged the need for preceptorship programmes for those who choose to work in the community. Although the aim of their education programme was to equip them for hospital and community practice, the latter was believed to be a different environment completely. Managers agreed with the need for preceptorship, particularly for the newly qualified diplomate, in order to develop their ability to cope within a community setting. The concern from management was for the provision of 'experience' within the limits placed upon them by skill mix demands. The need to establish an infrastructure to allow the Project 2000 qualifier an entry into the community was seen as essential. Their participation within community teams was seen to be limited more by the lack of structure, than by a lack of theoretical skills.

Shifting Ideologies

It emerged from the teachers, managers, and practitioners focus group data that there was little debate that the Project 2000 nurse brought with them a new perspective upon nursing. Two central themes emerged concerning their assessment of student's perceptions of the philosophy and practice of nursing. The first was the concept of the 'new ideology' within which nursing is now perceived to be embedded, and the second was the clear patient orientated focus.

A New Ideology

This perceived ideology complements the perceptions voiced by the nurse teachers surrounding the conflicts created when different nursing cultures meet. It was noted that definitions of nursing values have changed recently, compared to ten years ago. Comparisons were judged as hard to make accepting that it is only now that nursing is becoming more clearly defined, ten years ago people did not have at their finger tips these new definitions to use. One manager from the surgical speciality, suggested students from the Project 2000 curriculum in centre 1 talked about:

> *"the 'new nursing ideology' which they have heard in colleges of nursing as good; about nursing as being a therapeutic profession. Different things are coming out - because that is new in the literature, there is a new language required."* [p18:S1/M/5.10]

There seemed concern however as to whether the 'new' nursing ideology fits with the realities of practice. Across most of the focus groups issues emerged which reflect the potential clash of the new ethos represented in Project 2000, when meeting the demands of practice represented by the change in the NHS reforms.

It was acknowledged in both sites that government targets and policies were affecting the perceptions of nursing. There is now a general ethos toward health promotion rather than merely nursing the sick, this was fostered by policy documents such as the 'Health of the Nation' (D of H 1992), where individual responsibility for health was seen as important and now emphasised. The changes perceived in nursing were not solely placed at the door of Project 2000, it was seen as part of the whole 'process' of change and the domino effect. The changes in government attitude, and changes in the health service together with changing public opinion and expectations all affected the philosophy and practice of nursing.

The change in nursing itself was represented by the changes in the delivery of care as a result of financial pressures and government policy, such as the 'patients charter' (HMSO 1992) forcing a change in patient trajectories. Expectations of care from a nursing perspective have changed, in the sense that practitioners no longer aim for a 'total cure' prior to discharge, but aim to deal with the acute stage in hospital and then pass them onto the community services, as one manager from the surgical speciality in centre 2 points out:

> *"We don't get them totally well and put them to the community like we used to. We actually now can see ourselves as part of a wheel within a wheel: we are just part of it. We have shorter time with the patients, ...a shorter time to build up relationships."* [p.30-31:S2/P/30.11]

These pressures placed upon the nurse in the realities of practice appear to compete with the perceived 'patient centredness' of the Project 2000 nurses and with the ideals of our focus group respondents.

Patient Centredness

There was the belief from teachers, managers and practitioners alike that nurses have indeed always been 'patient centred' but that this focus is now strengthening. This was seen as an evolution into a more intensive, and much broader view where the nurse now co-ordinates, controls and decides the most appropriate person to meet the assessed need of the patient. The nurses skill in seeing the holistic perspective of care, was again linked to the need to justify the qualified nurses contribution to care, as one senior manager within paediatrics comments:

> *"within the context of the named nurse ...nurses there are able to give advice on health promotion. You name it, that nurse has that experience and the ability to apply that knowledge to that relevant family and that individual child within the family. This may be totally different for 20 others and that is what nursing has the ability to do. "* [p53-54:S2/M/20.10]

Nursing's strength was perceived, by the managers and practitioners, to be its ability to apply knowledge to individual circumstance, making it applicable and appropriate. For the senior practitioners holism was a foundation for their philosophy of nursing, attempting to provide the best care possible for the patient and the family, taking into account the total environment and circumstances. Seeing the patient within their family environment was seen as essential. The ability of community nurses to do this was highlighted by the senior practitioners working in the community. However for all practitioners in centre 2 the emphasis on seeing the patient within the family context was acknowledged:

> *"I have worked in the hospital a long time and it is surprising, you see somebody in a bed in a night-dress or pair of pyjamas, but when you go in the community you see them - sometimes you are shocked at the way people live, but that is that person and that is them in their entirety, and I think that is helpful. You do have to meet a lot of needs, not just the physical needs - social, spiritual, everything."* [p.36-7:S2/P30.11]

The delivery of care was concluded by all to have changed considerably, with the emphasis on holism and treating the patient as a person, not merely the disease, as illustrated by one medical nurse manager:

> *"you are trying to treat them as a whole, whether they are in hospital or out in the community, wherever - you are trying to take on board not just what is wrong with them but all their other problems as well and consider the family as well. I think that the care has improved because of that."* [p.31:S2/P/30.11]

Managers and practitioners alike seem under increasing pressure to justify why it is that nurses and only nurses have to do certain jobs - the holistic argument appears their first line of defence, but the question remains as to whether senior management see it as a credible one ? Senior nurses did as mentioned previously, acknowledge this pressure to explain to the 'trusts' why it is that 'G' grade nurses are needed, however as one manager within learning disabilities in centre 2 suggested:

> *"They do not appreciate, probably, the role and function of this holistic person who is there for everyone for all things. "* [p.57-58:S2/M/20.10]

A nurse teacher from centre two also doubted whether the trusts valued the emphasis placed upon nursing and basic nursing care as much as the new curriculum does. She suggested:

> *"My worst nightmare is that we will have a Project 2000 nurse, being in charge of a ward of health care assistants who will be carrying out the bedside nursing. And so my gut feeling is that this stress we put upon nursing in our curriculum is right, but I just hope that the trusts and the hospitals are going to see that it is important and not just pour it out the other end"* [NT /S2/p.31]

It was acknowledged that patients / clients have the right to 'individualised care'. That was accepted as a major change from the more traditional approach when standardised care was perhaps the norm. As one practitioner from neurology (centre 1) reflected:

> *"You might have six patients having the same operation, and whereas before they would all get standard care, they now can get very different care. [That's right] "* [p.27:S1/P/7.12]

This seems in contrast to 'traditional nursing' when standardisation was seen to play a more powerful role, the days of "the appendicitis in bed four" are now believed to have gone. The assumption that such an approach failed to recognise individual needs was however challenged, although the level of individualised care given was acknowledged not to match that of today. The more negative reminders of traditional practice were shared by one district nurse in centre 1, who trained in 1960:

> *"and found that they would rather you cleaned a cupboard three times a day than sat and talked to the patient.(Agreement)"* [p.27:S1/P/7.12]

Section Summary

There was a general feeling that perceptions of nursing had developed in line with evolving experience. The cause of this change was inconclusive and ranged from teachers own involvement in the higher education process through to the managers and practitioners own personal development. Participants spoke with greater confidence about the student's evolving perceptions of nursing. Teachers, managers and practitioners from both centres acknowledged a progression of ideas away from the stereotypical 'simplistic' notions of nursing, towards a more complex concept involving accountability and professional responsibility. The students initially placed greater emphasis on the more physical aspects of the nursing role, and gradually began to see the importance of holism and a theoretical foundation.

For the nurse teachers both their own perceptions of nursing and their beliefs concerning the students, centred around the significant changes occurring within the structure of the current National Health Service. The impact of the NHS reforms (Trust status and the Community Care Act), was seen to play an influential role in placing new demands upon nurses and their provision of care. The move to greater care in the community caused concern for many of the teachers, managers and practitioners. This focused around issues of support for, and preparation of current community practitioners. Practitioners and managers felt the role of the Project 2000 practitioner to be 'ill-defined'. The merits of the curriculum were acknowledged, and perceived to facilitate the health promoting influence upon community care. It was however, the 'structure' for the diplomates inclusion into the community team that was seen to be lacking. They concluded that the 'flexible practitioner' with the ability to practice between hospital and the community was yet to be established. For all focus group participants however there was little doubt that the Project 2000 nurse brought a new perspective on nursing. Definitions of nursing were perceived to have changed and only recently had nursing become more clearly defined. However, there was concern that the 'new' nursing ideology did not fit easily with the realities of practice within the reformed NHS. Patient centredness was a good example of this , where holism and individualised care was valued highly by the Project 2000 nursing curriculum, but was not always appreciated by hard pressed purchasers.

5. 2. "PROJECT 2000" AS A PREPARATION FOR PRACTICE AND SOCIALISATION INTO THE PROFESSIONAL ROLE.

A question of whether the Project 2000 course provided an appropriate preparation for practice and its contribution towards the process of socialisation into the professional role were posed to nurse teachers, senior nurse managers and practitioners. Four major consensual themes emerged from the focus group data. These revolved around the issue of whose responsibility it was to impart clinical skills, the need to provide a sense of belonging and support and the acknowledgement of the need to get 'the balance right' between theory and practice.

Imparting Clinical Skills - Whose Responsibility ?

There was general agreement across all groups and between each centre that the clinical practitioners were seen to carry the major responsibility to impart clinical skills. Nurse teachers in centre 2 pointed to the fact that 'rightly or wrongly' they had adopted the attitude that it is the practitioners duty to teach the students their practical skills. The nurse teachers had the responsibility of helping to prepare the clinical staff for their teaching role on courses such as the ENB 998. Senior nurse managers in centre 2 also accepted this responsibility whilst acknowledging the pressure it can place on first level nurses. Nurse managers in centre 1 were the only group not to mention this issue directly. The nurse teachers saw their role very much as one of support for the clinical staff. It was recognised that since the implementation of Project 2000 many of the clinically based staff were progressing in their own educational development, and the nurse teachers felt that their role was one of support, as much for the practitioner in achieving their educational aim, as for the student. There was an acceptance by the nurse teachers themselves that it is the clinical staff who are seen as 'the experts' of care and the nurse teachers should provide background information, leaving the former to teach the clinical skills. Whilst the basic premise was accepted within centre 2, the nurse teachers debated the potential need for their profile to be increased, with some seeing the total handing over of responsibility to the clinicians as a 'cop-out'. Their major concern was the constraints the practitioners themselves were under, in terms of work pressures and priorities. Clinical staff were not perceived to lack motivation but had to respond to other demands placed upon their time. Practitioners in centre 2 turned the concept of the lecturer - practitioner on its head, advocating that of a practitioner - lecturer. They acknowledged that expectations of having clinically credible nurse teachers were too high, and felt it would be more appropriate for the practitioners to teach the students in the college environment. The availability of time seemed to be a short term problem, however the longer term gains were acknowledged:

> *J: "I know it is time again, but we will get better staff nurses in the end that you can leave in charge sooner which will save time - its a vicious circle."* [p.29:S2/P/30.11]

The practitioners seemed to accept that clinical credibility was not the most profitable attribute a nurse teacher could have, instead they looked to them for their rather more academic skills:

> *J: "I think perhaps we are expecting too much of them to come in and be clinically credible. It is too much. We need to use them in their capacity, in their ability with research and theory."* [p.29:S2/P/30.11]

The nurse teachers themselves, particularly in centre 2, saw little advantage in the 'rolling your sleeves up' approach to supporting the students in clinical areas. Their perceived contribution complemented that of the practitioners expectations, of a more facilitating role, talking through experiences faced in the clinical areas. The role was seen to be one of identifying the students needs and discussing how to meet them.

The practitioners saw nurse teachers themselves as placing clinical skills low in their priorities. Community practitioners in centre 2 recognised that nurse teachers had themselves been acquiring new 'academic' qualifications, and have along the way "lost their practical skills". When this occurred the responsibility for imparting clinical skills was seen to be firmly in the hands of the practitioners. For the learning difficulties branch offered in centre 2 only, the major concern from the practitioners was the evolving role of the service and the relatively new demand for clinical skills. Some of the teaching staff were seen to have trained when such skills were not associated with the role. The nurse teachers were therefore seen to lack the skills themselves, whilst potentially not acknowledging them within the current learning objectives. Managers in learning disabilities within the same centre acknowledged the shift in service, once based upon a medical model and now on the principles of normalisation, choice and advocacy. The concern centred around the students' perceived lack of basic skill acquisition. In centre 1 the nurse teacher representing the child branch showed similar concerns regarding the acquisition of clinical skills:

> *D: 'when I look at some of their academic work, and I look at their unseen examinations, I am very worried about their skills and their lack of understanding of how important it is to prioritise and to assess patients. It is concerning, is it not, when you have a scenario with a six week old very sick baby, and they know how to assess the spirituality of that baby but they do not know how to take the observations and vital signs of this very sick baby. '* [S1/NT/13.7 p.20]

This particular nurse teacher felt the students were indeed getting a broad input about a variety of issues from, politics, the NHS, organisation and management but somehow they were unable to nurse sick children competently. Whilst the issue of the practical skill acquisition was acknowledged as a worry by the nurse teachers, practitioners and managers there was an additional benefit seen from the new curriculum, that of the students ability to reflect. However, an ethical concern was expressed by the nurse teachers regarding the aim of producing these 'reflective

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practitioners'. The negative effect was seen by one nurse teacher from centre 1 (community) to raise anxieties for the individual student / nurse concerned because:

> *"when they look at what they are doing or what they want to do, they are not allowed to do what they should be doing because their work is determined by the business culture and all the rest of it, then to want to be truly reflective in that kind of environment is particularly scary. You go home every day reflecting on your practice which is awful because the environment in which you are working is not going to allow me to change that."* [p.26-27:S1/NT/13.7]

Reflective practice was seen by some to facilitate the acceptance of such constraints placed upon nurses. Although capable of causing anxieties it would perhaps enable the individual to cope better with them. The Project 2000 curriculum was seen to be based on a 'pro-active philosophy' with the production of a reflective practitioner as an explicit aim. The majority of practitioners did accept the pressure nurse teachers had been under and felt that it was the clinical skills which were first to give. They did acknowledge the need for clinical liaison between teaching and clinical staff, although there appeared little grief at the loss of the 'clinical tutor'. The main role was once again seen to be in the area of 'research', primarily as a source of information to enable practice to be grounded in research and theory.

> *"if she can tell us research so that we can bring that in with the student in the practical setting, great- but practically we are responsible for training."* [p.26:S2/P/30.11]

Practitioners particularly in centre 1, whilst agreeing with the premise that responsibility for clinical skills should be their domain, accepted that they themselves needed to adjust to the new education programme represented by Project 2000. Students were seen to be contributing a lot to the course itself and the practitioners recognised that it also demanded a lot from them, in terms of supervision of specialised activities, such as 'ward rounds', 'aseptic technique' and 'drug rounds'. The perceived 'lack of structure' around the students learning objectives was seen as an issue that some practitioners felt they needed to adjust to. Traditionally certain skills would be expected from certain placements and practitioners knew what was expected of them to achieve that set outcome. Today the objectives are perceived to be more open and undefined. Structural constraints were also acknowledged as contributing to the difficulties around the students meeting their learning objectives:

> *"But something as general as drugs - the thing is, now we do drugs on our own, whereas before there were always two people, so you automatically had a medium for a student to be there checking with you. And now a student has to be a third nurse and if there are only three on duty........."* [p.14:S1/P/7.12]

The practitioners took their responsibility for teaching the students their clinical skills very seriously whilst accepting that the complete process was a shared one, between the students themselves, practitioners and teachers. Teachers were firmly given the responsibility for imparting the more theoretical aspects of their educational process and the practitioners were given the remit of implementing the practical side. The existence of the 'link tutor' was discussed, and in centre 2 was considered not to be working, however the value of having such a system in place was accepted.
This shared responsibility for educating future nurses was also seen to have a positive effect for professional development in general:

> *"One of the welcome changes has been seeing staff nurses who, five or 10 years ago, would never have felt competent to do some of the things they do now. When the student goes into the ward now, they have a programme, the student will follow those experiences."* [p.30:S1/NT/13.7]

Nurse teachers in both centres did accept that most students towards the end of their course would state they felt unprepared for qualified practice. This was seen as no different today for the Project 2000 student, as for the traditional students. It was questioned as to whether traditional students, although 'thrown in at the deep end' were actually picking up skills as accurately as they should have been. There was an argument put forward that perhaps they were just 'picking up how to behave' so they appeared [illegible] doing things well. Project 2000 students on the other hand through their observational / supernumerary status are no longer 'thrown in at the deep end' and so are not given the 'opportunity to imitate' or practice, and so do not learn quite how to behave. This was one explanation given by a nurse teacher in centre 1 (adult) for their apparent initial lack of skill. The development of 'skills labs' was perceived by one of the nurse teachers in centre 1 to widen the perceived theory -practice gap:

> *"I do see that as a potential problem in the development of skills laboratories. I almost see that as teaching skills outside practice, particularly where you see the development of assessment and skills laboratories; we just seem to have turned the clock back and not learned by our original mistakes. I think there is a real problem here."* [p.22:S1/NT/PM]

Although the development of clinical skills was seen to be important, it was also recognised in centre 2, that it was essential to take 'theory out into practice'. It was undisputed that practitioners had little time for supervision, although it was advocated by one nurse teacher that the mentors should be regarded as part of the college, seen as part of the teaching programme, and viewed as an additional teacher.

The Students' Need For A Sense Of Belonging

Nurse teachers in centre 2 saw it as positive that the Project 2000 students were slightly more distant from what was going on in the clinical team. This enabled the students to 'take a step back and get more of an overview' of life in practice. It was hoped that such a position would facilitate a more 'objective assessment' from the student, allowing them to differentiate good points about particular roles that they saw, whilst noticing some of the bad ones without always taking them on board.

Practitioners in centre 2 perceived the Project 2000 students as being at a disadvantage in comparison with 'traditional' students in their constant pressure to adjust to new situations without feeling settled for any length of time. They believed that students enjoyed feeling part of the team and that it was their loss when such a feeling was not established. Nurse teachers in centre 2 reaffirmed the view that students are no longer 'part of the ward culture'.

Project 2000 students' new role was one of 'observing' in contrast to the traditional role of doing, these was seen to separate the student more so than before, as a nurse teacher (CFP) in centre 2 states:

> *"What I think is explained is that they cannot do these things. It is very much about doing and one of the things I say to Project 2000 students, which seems to sink in, is that they can look to see how work is organised and see what is going on [agreement]. Therefore to me they always feel a little more separate than I was and other students have been."* [p.8:S2/NT/1.6]

Supernumerary status was also seen to be instrumental in determining their clinical role and inclusion or exclusion within the team. There was a definite shift in their perceived status within the team once the students were in 'rostered' service, as the following dialogue with the focus group facilitator (researcher) and one nurse teacher in centre 2 highlights:

> *G: "Much of it is also to do with their supernumerary status. You can definitely see a shift once they rostered into practice because their status within the ward team changes."*
> *A: "How does that shift manifest itself?"*
> *G: "In the student's confidence I would say. I do not know whether that is because they are further into the course and they have better skills to back them up and to give them that confidence. But I think it is also the socialisation that makes them feel like that."* [p.8:S2/NT/1.6]

Nurse teachers acknowledged the traditional and continued danger encountered when the student meets the socialisation process of the clinical area. As a nurse teacher in centre 2 (CFP) articulates:

> *"I have seen it at other times where people become socialised into that area and what goes on in that area. Although they may come in as very different, they very soon end up the same colour as the rest of the washing."* [p.S2/NT/1.6]

Practitioners in centre 2 highlighted the fact, that for some, success continues to be measured in the students ability to 'pick up the ward routine'. Students were well regarded when this was achieved. This was accepted by the nurse teachers who appreciated the potential dilemmas when the process of assessment was linked to the issue of mentorship. The honesty of the relationship established was in doubt when the preoccupation of the student concerned, revolved around 'what would go in their assessment'. The nurse teachers were aware that a lot of responsibility had been handed over to the mentors, and with this responsibility went an assumption about the quality of mentorship which was being provided. Part of their role was, they believed to support the mentor, who would in turn provide better support for the student. The level of support given by nurse teachers to their clinical areas was seen to depend, in centre 2, on the personal level of commitment each teacher had to their clinical link areas. This process began with the commitment to keep a reasonable link with the area by maintaining regular contact . Beyond that much was seen to depend on how the staff wanted to use the educationalists and how secure they felt about their relationship with them. If the level of contact was maintained the benefits were seen to provide a more tailored service, for mentor and student alike, as stated by a nurse teacher (CFP) in centre 2:

> *"You can then be more responsive to their needs - how they want to access you; do they want help with literature search; do they want to go back into the school and be there or do they want you more in the practice."* [p.15-16:S2/NT/1.6]

Any input given to the mentors and trained staff themselves was considered to have an impact upon the level of supervision for the students. The desire of the mentor to continue their learning curve was seen to have a 'cascading effect' not only upon students but also upon colleagues. In fact the influence was two way, with the Project 2000 students seen as the initial impetus for the search for post basic qualifications. This relatively new aim for the 'life long learner' was seen to be a two edged sword, with the benefit to improving care whilst adding to the pressure already increasing upon hard pushed clinicians who now have to reach the next goal of 'specialist practitioner'. Such achievements were seen as positive, but with the very large proviso that:

> *E: "there are the support systems in existence"*
> *B: "That is the thing that is missing, but it is missing now."* [p.23-4:S1/NT/13.7]

It was the managers in both sites that mentioned the importance and constraints placed upon them by larger structural issues. The current environment of 'constant change' has increased the pressure upon managers to provide 'continuity' of support for their students and staff, this seemed to be exacerbated within the community domain. There was some dispute amongst the managers in centre 1 as to whose responsibility it was to ensure the 'co-ordination' of the students experiences and the level of support they receive. The consensus opinion was that the responsibility to offer the places, make them as good as possible, provide the buddy or support system to ensure a good experience, lay firmly with the practitioners, while the responsibility to co-ordinate that across the three years was that of the educationalists.

In the discussions with managers concerning the provision of support for students within their clinical placements, the lack of resources were seen to be a significant inhibitor. Blending the objectives of standard setting, monitoring and audit, with the highlighting of training needs all depended upon the provision of resources to facilitate the assessed need being met. The statutory pressures for the mentors to be 'first level nurses' and completors of the 998 course, ideally, when blended with skill mix and the reality of 'trusts' and financial constrictions, places managers under further pressure. The managers lamented their perceived failure at times to provide the support for both students and trained staff that they would wish to give. One effect of working within the financial culture of the 'trusts' resulted in those most suitable for mentorship, the 'E grades', more often that not finding themselves in charge and so unable to give hands on care and supervision.

Some managers felt a return to the 'old system' of a years staffing at the student's teaching hospital had merits which could be useful for the Project 2000 qualifier of today, gaining a period of time set aside to learn to be in charge of a clinical area, although not actually given full responsibility for it. Supervision was the expected norm although less formalised than the 'preceptorship programme' advocated today. The most comforting thing, as two managers (mental health / plastics) recall was the fact that:

> *B: "The organisation would know what they could expect from someone that staffed in that environment."*
> *D: "You were allocated a mentor. It was just not called a mentor. You were told you will stick with Staff Nurse whatever her name was."*
> *B: "Lets go back to the old system."* [p.10:S1/M/5.10]

This expectation continues today, from the managers within 'specialities'. They appeared to accept the need for, and have established, preceptorship programmes of their own. They have traditionally never expected any pre-registration course to equip any diplomate nurse with skills needed for their own specialised practice. In house post basic support was an expected requirement (see section 5. 3. for further exploration of this).

The Theory Practice Gap - Getting the Balance Right

The nurse teachers, across the centres, recognised that the students had a strong desire to practice, "wanting to get out there". Placements were felt by students to be too short with not enough time for practice in general. There appeared a general agreement that students' view of nursing evolved as they progress in their course. The early views of new students, were seen to involve the expectation of spending very little time in school progressing rapidly into the clinical areas to fulfil the desire of "wanting to have their hands dirty". This concept of 'getting their hands dirty' was seen to relate to the practical skills of giving injections, completing BM tests, and passing naso-gastric tubes. The high priority given to the completion of such tasks was considered equally relevant for mental health as for adult students. The tutors felt that there continued to exist a very pervasive 'social image' of nursing and this was portrayed in their desire, especially for the new adult students to "get their uniforms on".

There was the idea that the students needed to be able to measure their own sense of 'progress" and this becomes more sophisticated as they progress in their course. Their desire for 'hands on' practical tasks gradually gets replaced by a desire to become more proficient at more complicated activities. The nurse teachers recognised that the students themselves needed to be able to acknowledge and then assess that progress was being made. Getting a uniform is perhaps one of the most overt indicators of progression. This is followed by the accomplishment of more physical tasks such as giving an injection. In comparison to the more covert measures, as two nurse teachers (both teaching on the adult branch) from centre 2 state:

> *B: "It is very hard, for example, to see that you are now a better communicator, unless you sit and reflect periodically over the whole course and say, yes, I handled that much better."*
> *G: "Initially they will object and say, 'I want to give an injection during this placement, I want to do a dressing'. Gradually they broaden their scope and they say, 'I would like to be more assertive, I would like to have the confidence'. They talk more generally and that shows a bit of growth and maturity."* [p.26:S2/NT/1.6]

Initially the relevance of theory seems overshadowed by the students desire to practice. Nurse teachers saw it as their responsibility to attempt to "create the want" to learn, and facilitate the student to recognise that theory is essential, if not of immediate interest to them. There seemed a reluctance on the part of the diplomate student to see 'theory' as part of nursing. This perception was consistent across sites and branch programmes. As one mental health tutor from centre 1 comments:

> *"some of the students kept saying, why more theories, more psychology, sociology, I'm here to be a nurse, to do as they do".* [p.18:S1/NT/13.7]

Nurse teachers felt that this was often problematic with the introduction of theory earlier on in the course. The students perceived subjects that are more overtly related to practice as taking greater priority. Subjects such as biology and practice skills are requested whilst they fail to see the relevance of the other taught theoretical perspectives. There was a concern, more from centre 1, that there could be a danger that too much theory was now given out at the expense of "simple things". One adult branch nurse teacher, from centre 1 stated:

> *"It is a practice-based job when you look at it, and I have worries about that. Sometimes when you read examination papers, sometimes you get that they can counsel the patient to death! But they cannot do the basics."* [p.22:S1/NT/13.7]

One child branch teacher from centre 1, believed one possible cause for the difficulties in relating theory to practice, is as the students had said themselves, 'the fact that they do not feel at the centre of the curriculum'. It is seen, she believed, as very fragmented for them and the connections were perceived to be hard to make. This was a view point supported by the mental health teacher in the same centre, who made the point that the teachers ultimate aim was to produce 'good practitioners' but questioned whether teachers after 'teaching' their subjects, applied them:

> *"do we apply this, or do we just give them the theory and assume that their mentors who are the clinical practitioners and the carers will do this for us ?"* [p22:S1/NT/13.7]

It was acknowledged in centre 1 that the new Mark II curriculum has started to address this issue. Centre 2 felt quite confident that as the course progresses the reasoning behind the course and its organisation becomes clearer for the student. From an initial questioning of the need for such theory and doubt as to its potential application to practice, nurse teachers felt that eventually the "penny drops", as one mental health teacher stated:

> *"But later on when they come to Unit 5, when we begin to tell them the philosophy of Project 2000 which is basically we want to produce somebody who is a knowledgeable practitioner, somebody who can work in the community and a non-community setting, and somebody who can meet the health needs of the population in the late 1990s and beyond. Then they begin to recognise that they are being trained to become a different sort of nurse - the penny drops so to speak. So that is the difference which I see between Unit 1 and Unit 5."* [p.25/26:S2/NT/1.6]

As this penny drops the need for a broader base of skill becomes more apparent with interpersonal skills, research and a critical approach becoming valued. communication skills are seen as essential in the branch programme, incorporating the need to liaise and negotiate and develop rapport with a variety of people. Similarly the value of research is perceived to be recognised towards the latter part of the course, with the need to keep aware of current research findings in order to implement or change practice. From this develops the 'critical approach', and questioning in general. This was seen by nurse teachers in centre 2 to be one of the spins off of the new academic level attained in the Project 2000 diploma course, eventually producing an ability in the student to argue from different sides in the hope that such an approach would carry through to their practice.

In terms of achieving a 'balance' between theory and practice, two main areas were explored within the focus group discussions, with all but the practitioners in centre 1 mentioning the need to blend theory with practice. The second issue addressed was that of the need for realism within the educational outcomes for the students, this being a request which came from practitioners and managers only.

Practitioners appeared to criticise the fact that nurse education had historically concentrated more upon practical issues than theoretical perspectives. However they perceived the current Project 2000 curriculum to have diluted their influence upon the student nurse by their constant oscillation between college and practice. They did acknowledge that traditionally there was not enough emphasis placed upon the need for theory and research and accepted it as an important issue for the students of today. The need to maintain a balance between the two was acknowledged. Practitioners at times felt that the students unbalanced the weighting given to academic work at the expense of 'mundane tasks'.

Nurse teachers perceived the amalgamation of nurse education with the higher education system as an influential factor affecting how students bring theory into the realm of practice. There was dispute among nurse teachers in centre 2 concerning the impact of 'modularization' on the application of theory to practice. Some saw it as extending the division of nursing into distinct 'units of knowledge', others saw the process as potentially linking theory closer to practice, as one nurse teacher (adult) in centre 2 states:

> *"That is what some of these practice models will allow us to do. But there is no running in tandem with the theoretical model. We should be able to do that using theory modules alongside the practice modules and the practice module will have built-in tutorial time. I do not know if it will but I would like to think it will get better but it is difficult having a knowledge and then trying to put it into practice without somebody helping you to do that. It is difficult for qualified staff."* [p.20-21:S2/NT/1.6]

Linked to the aim of reducing the perceived theory practice gap was the need for 'realism'. However nurse teachers did not mention this need. Connected to the attempt to increase the 'realism' of educational objectives was the concept of better liaison between educationalists and the service sector in general. In centre 1 psychiatric and community practitioners, and community managers were particularly critical of the poor liaison. There was a request to have increased contact with the teaching staff. As one community practitioner from centre 1 states:

> *"After Christmas we are meant to have five community tutors that are going to be based down at the community for two hours a week. We have not seen any so far, so two hours would be brilliant for us."* [p.41-42:S1/P/7.12]

Centre 1 appeared to show most concern regarding the lack of preparation and support they had received prior to the Project 2000 students going out into their community placements. Practitioners felt strongly about the lack of information given to them prior to the students arrival, so much so that they eventually demanded the nurse teachers came out to the community to explain what was happening. The increased through put of students lead to other concerns for both the student and client, as one community district nurse in centre 1 stated:

> *"There were 170 sent out into the community, so a lot of us have had to take two students - I have had two - because there was not enough placements for them all. But they decided that they should all go out, the whole 170 of them, into the community."* [p.43:S1/P/7.12]

Psychiatric practitioners felt it important for the teachers to have appropriate knowledge concerning the placements their students would attend. This was seen as essential if the nurse teacher was to advise the student as to which might be most appropriate to meet their personal needs. It was also considered important for them to gain an understanding of what students were feeling about the problems they had encountered. Once again both the practitioners and managers appeared aware of the increased pressures placed upon nurse teachers, acknowledging a change in their role. There was general agreement that they were not around the clinical areas as often as they needed to be, although it was accepted that the teachers themselves would probably like to be more active in the clinical arena, given the opportunity to do so.

The role of a 'link teacher' was seen in principle to be a useful concept in bridging the gap between education and practice. Many managers however, feared that the 'liaison' role would be jeopardised further by the effects of the new ENB recommendations (ENB 1989b) concerning the one day a week that each nurse teacher would have to spend in practice. Managers believed this would result in them seeing even less of the nurse teachers than at present. There was a belief that perhaps the scales had tipped in favour of theory but at the expense of practice. The following statement was shared by a manager responsible for cardio - thoracic area in centre 1:

> *"When we had the old style training they had a load of practical skills and perhaps lacked the theoretical base. Now they have got that theoretical base but they lack practical skills. It seems the balance has gone the other way. It would be nice to get it nicely balanced."* [p..9/10:S1/M/5.10]

It was acknowledged that theory and practice should be balanced, with lessons to be learnt from the university system with theoretical input related firmly to practice. This was confirmed in centre 2 by community practitioners, who felt the Project 2000 students they had come into contact with were indeed very knowledgeable, from their increased theoretical input, giving sound advice to both the patients and their families. However:

> *"My reservations have been mainly on the practical aspects of the care, but theoretically I think it is a much better training. But I think it is suffering somewhat with the practical input that they get, and if the two could marry up then it would be absolutely brilliant."* [P8:S2/P/30.11]

Project 2000 students were seen by senior educationalists to be more realistic about the context within which they found themselves. Employment prospects were mentioned as perhaps the greatest change in terms of expectations for qualifiers. They were perceived in the initial stages of the course to be 'idealistic' but progressed to a more 'realistic view'. Idealistic concepts were seen to be of little value for 'realistic' practice. There was seen in centre 1 to be a better balance now between what is the ideal and what is real. It was seen as important that the students and qualifiers:

> *"know what the ideal is and they know that in the current climate they cannot achieve it."* [p4:S1/NT/PM]

Section Summary

The nurse teachers, managers and practitioners all concluded that the ultimate responsibility to impart clinical skills lay with those considered to have the relevant expertise - the practitioners themselves. The nurse teachers were seen to make their greatest contribution towards socialising the student into their professional role by using their 'academic' expertise rather than competing for clinical credibility. In general, nurse teachers concluded that supernumerary status had as its greatest advantage the facilitation of an objective assessment of practice by students. Practitioners felt this to be at the expense of losing their 'sense of belonging'. Concern was expressed that often 'success' remains wedded to notions of 'picking up the ward routine'. A commitment to 'lifelong learning' was noted but both managers and practitioners felt increasingly constrained financially in providing the kind of support they would wish to provide for both students and diplomate nurses.

There was a perceived need by all groups to regain and maintain the balance between theory and practice. Practitioners felt that historically the latter had taken too great a precedence. However, the pendulum was now seen to have swung too far in favour of theoretical issues. The effect of this change in direction was seen by managers and practitioners alike to have increased the idealism of students. One solution proposed to reduce such an unrealistic perception of nursing was to increase and improve the liaison between educationalists and service providers.

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5. 3. PERCEPTIONS OF THE PROJECT 2000 QUALIFIER AS A PROFESSIONAL PRACTITIONER

Senior nurse managers and practitioners were asked for their perceptions of the impact of the Project 2000 curriculum on the diplomates as professional practitioners. They were also asked to indicate whether the course was providing the type of nurses they required. Without exception the general response to these question was a confirmed 'yes'. Following the general agreement that this was the case, four major consensual issues arose from their respective discussions. They all saw a need for the diplomates to be adequately supported in their initial post registration period. This view was linked to their perception of the Project 2000 practitioner bringing with them an 'initial skill deficit'. However, they challenged the expectations that were placed upon the diplomate nurse, accepting that they continue to be unreasonably high today as they were historically. Finally the Project 2000 practitioner was seen to bring with them a new perspective upon nursing. These perspectives were seen to be surrounded by a changing environment of care, which at times produced its own conflicts.

The Diplomates Need For Support And Supervision

Managers and practitioners, from both centres articulated a perceived responsibility to 'nurture' the newly qualified nurse. The need for greater supervision and support was high on their agenda. Managers from both centres saw the Project 2000 diplomate as requiring a greater degree of supervision in the initial post qualifying period, and the importance of a 'preceptorship model' was acknowledged. However, the quality of supervision currently offered perturbed the managers, who felt they were failing the Project 2000 newly qualified nurses at the 'supervisory level'. This opinion was highlighted by one manager in charge of coronary care, in centre 1, who stated:

> *"I believe that the structure of the training is better, that their depth of knowledge is better, and it does not take a highly motivated person long, provided they are given that amount of supervision. And if you can get that bit right, then the pay-offs are enormous. But at the minute it is the supervision, the mentorship, the preceptorship - whatever you call it - that we are struggling with. They are so idealistic, so enthusiastic, and for whatever reason it is almost as if we are failing them at the supervisory level."* [p.7/8:S1/M/5.10]

There was an idea that the 'right environment' should be created for them in order to facilitate a culture of growth. The potential was clearly seen, however the realisation of it seemed held back by restricted funding, as a manager from surgery in centre 1 reflected:

> *"I see a workforce with tremendous potential and that workforce needs to be nurtured, and you have got to give them an environment, you have got to give*

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> *them that supervision. But you have limited resources. You have a costing programme of 3% compounded every year, and it is difficult."* [p.8:S1/M/5.10]

Resources, as ever, were seen as problematic, and for the managers, responsibility of supporting both students and newly qualified staff was seen as a heavy burden. Many stated they were 'thin on the ground with trained staff'. Resource implications were seen to have detrimental effects on student learning and support as the following dialogue between senior managers highlights:

> *G: "I am not opposed to developing them, but what has come out of this meeting is that, certainly in the community, I feel we are letting them down because we have not the resources, we have not produced and enriched the staff that are mentoring these students and nurses of the future in a way that I would like to have seen,...So I would say it is not so much the actual concept of the education of a Project 2000 nurse; it is the climate that we are in that is affecting a lot of stuff at the moment."*
> *D: "Basically, it boils down to politics and finance.[agreement] If you had the finance you would be able to buy adequate staffing levels, you would be able to provide money for training - all the other things that you could do that you are restricted by because of lack of money. A lot of the lack of money is due to the reforms in the health service and the political changes."*
> *E: The 1991 reforms are probably the biggest influencing factor [agreement], I think, upon where nursing is...purchaser-provider split, an internal market - it brought in competition, it brought the need to be more cost-effective and efficient than ever before. And we are struggling. You are right."*
> *G: "I think that the curriculum of Project 2000 is trying very hard to address all of this."*
> *E: "It is the rest of it that is failing them. The Project 2000i s fine. "* [p.26:S1/M/5.10]

There seemed a belief that pre-registered experience of the Project 2000 students provided little time to consolidate practice. This lack of consolidation was seen to have led to a lack of 'realism' and perhaps an increased sense of frustration.

> *"They cannot understand why they cannot do everything that they have been taught to do straight away. Yes, they need the support but they cannot quite understand that there is not enough money to have more nurses to let them do what they have been trained to do. That is missing from the training. They are in my area for 16 days at a time and you do not get an idea of an area. They are flitting through an awful lot of areas."* [p.15:S2/M/20.10]

The practitioners focused more upon the need for a 'breaking in' period, to consolidate what the students had acquired in their education programme. Nine months to one year was seen as a necessary period of post basic experience to enable the nurse to begin to see beyond the responsibilities of their own patient group. Clinical skills across the branch areas were seen to 'improve vastly' between six to nine months.

Lack of confidence was seen as an issue by practitioners, in both sites, and was believed to be primarily caused by the "lack of hands on experience". Compared to traditional students, Project 2000 diplomates were seen to need more support in the decision making process, particularly concerning management issues. Encouragement was needed to facilitate them gaining the confidence needed to take decisions. This was seen to be caused by a reduced exposure in their education programme to being placed in positions where decisions had to be made.

There was a general recognition that regardless of the style of nurse education completed, everyone would benefit, or would have benefited from a six month to one year preceptorship model upon qualification. The transition from student to staff nurse was universally seen as an enormous transformation to complete, regardless of the type of preparation. Whether Project 2000 diplomates or traditionally trained nurses, the anxiety surrounding that transitional period was strongly acknowledged by both practitioners and managers, as expressed by one mental health practitioner in centre 1:

> *"It is a massive step isn't it" [p.17/18:S1/P/7.12]*

There was a consensus that the Project 2000 qualifier needed more support than the traditionally trained nurse, however this in itself was not seen as negative, although for the managers concerned, perhaps a little frustrating within the financial constraints that are placed upon them. One manager from medicine in centre 2 felt particularly strongly about this:

> *"I am speaking purely from the hospital ward-based service...You cannot just toss them the keys and say, 'There is the drug trolley - get on with it!', like we used to do and as was done to us. However, I do not think that is necessarily a bad thing. It can be frustrating at times but it is not necessarily a bad thing."* [p.14:S2/M/20.10]

The managers in centre 1 challenged whether the concept of 'life long' supervision had been grasped by nursing in general. There was, they believed, little evidence on 'the ground' of the whole workforce receiving supervision. This fundamental principle was seen as a prerequisite if the concept of support for the diplomate nurse was ever to be accepted. Senior nurse managers were also not excluded from the issue of supervision. Some managers in centre 1 thought that there was a need to continue the process of change through the provision of continuing education. There seemed little sense in producing diplomate nurses to then allow them to become 'staid'. There was a need to keep up to date with current issues in an attempt to match the pace of change and deal with the pressures facing those in the health service in general, accepting that care and systems are dynamic things.

The Knowledgeable Doer with an Initial Skill Deficit

There was a belief from both managers and practitioners alike that the practical experience of the Project 2000 students, was now too fragmented with fewer placements for such short lengths of time. A general concern was voiced by the practitioners concerning the acquisition of defined skills such as, 'aseptic technique' and drug administration. These opinions were also confirmed by the managers, as illustrated by one in centre 2, within paediatrics:

> *"yes they do know the theory of how to do aseptic technique but they cannot always put it into practice, they cannot apply all this knowledge that they have, because of these short, frequent placements and a variety of other factors. Others can say what they feel but I find that the nurses have all this knowledge and do not have the time to put it into practice".* [p.32:S2/M/20.10]

An outstanding concern for the practitioners across the sites was the issue of preparation for night duty. Both students and qualifiers were perceived to be intimidated by the prospect of night duty. Time spent on night duty in pre-registration was considered minimal and inadequate to prepare them for the challenges faced once qualified. Psychiatry in centre 1 had now included this experience in their preceptorship programme, with the aim that it would facilitate newly qualified Project 2000 nurses to apply for the night duty posts available. Support was seen as an issue of concern and night duty a time of great vulnerability for the diplomate nurse. This was a view shared by one practitioner in centre 2 on a medical ward:

> *"The majority of people who are now newly qualified in a hospital are in internal rotation and they can get the support on days and you can give them a certain amount of help and all the rest of it. But on nights they are down to minimum numbers and there they are very vulnerable."* [p.17:S2/P/30.11]

The managers posed the issue themselves of what should be the major priority for pre-registered nurse education, should it be the acquisition of practical skills or the understanding of nursing theory. The proposition was seen by one clinical nurse manager within mental health in centre 1, to be a 'chicken and egg' situation:

> *"To have someone that does have these practical skills - and, however well qualified we are, we cannot deliver any of it unless we have these skills. Do we have a workforce that has those abilities and then facilitate their education? Or do we do it the other way round? I don't know what the answer is to that one. But it is annoying to find people educated by Project 2000- and we do get them - who come out at the other end and cannot deliver; they do not have that inherent personality or whatever it is to interact with people to deliver health care. I know the old system that individuals who fitted that profile as well, but perhaps the system was such that they did not get as far through."* [p.8:S1/M/5.10]

In answer to such a question the general agreement from both managers and practitioners was one of requesting a practitioner with "more practical skills". What the managers wanted were "practitioners who could practice their skills".

Reviewing Expectations Of The Diplomate

Managers from both centres felt quite strongly that expectations have historically been, and continue to be too high for the diplomate nurse. It was acknowledged by managers in centre 1, particularly within mental health, that the traditional diplomate did not come out 'perfectly formed':

> *"Surely they have professional and clinical development to attend to once they qualify."* [p.27:S1/M/5.10]

The practitioners challenged one another, confirming the concerns of the managers regarding the expectations held for newly qualified staff. As practitioners from centre 1 discuss (urology / general surgery):

> *B. "It concerns me a little bit about what your expectations of newly qualified staff are, though. There is lots of talk that they are just qualifying and they are not ready to be left in charge and not ready to do this, that and the other. We should not be expecting that of newly qualified staff anyway, whether they be Project 2000, whether they be traditional."*
> *C. "It is bad really when you think that in the past you were left in charge."* [p.17:S1/P/7.12]

The specialised areas appear not to have the same assumptions or expectations regarding the neophytes role immediately after qualification. Managers within the specialisms admitted that the traditional style of training did not provide them with nurses who had the necessary practical skills either, they have always had to provide 'in-house' training and supervision. Therefore such a deficit in Project 2000 nurses was not seen as significant. The managers within the specialisms were generally impressed by the nurses they had employed from the Project 2000 courses, as shown here by managers in centre 1 from cardiology and burns and plastic surgery respectively:

> *E: "I like the Project 2000 nurses that come out. I employ them I like them"*
> *H: "The Project 2000 girls that we have had have been excellent because burns, like you, is something that they may never do in training. But there is a lot of training to be done once they have qualified. But they do pick things up quickly, they learn much more quickly."*
> *E: "Yes very quickly "* [p.11:S1/M/5.10]

They voiced the need to be able to get every area, not just the specialised areas, to realise that they will all need a programme for post qualification support. A manager in a specialised area reflecting on the role of Project 2000 diplomates commented:

> *"what we need to do is to get every area not just the specialised areas to realise that they will need a nurse programme after qualification. The days of being able to take them off the shelf and use them on day one have gone"* [

The expectations of qualifying students was challenged, by the nurse teachers, in much the same way as the senior managers and practitioners had done. Again the issue of post basic development was voiced, accepting that Project 2000 students, in much the same way as traditional students, and indeed nurse teachers themselves when they were newly qualified nurses, only really start to learn particular skills needed when placed in a particular clinical environment. They acknowledged that the preceptorship programme was not fully functional and therefore it is perhaps harder for the Project 2000 diplomate.

The Questioning Diplomate as Potential Change Agent

When asked if the Project 2000 curriculum and the 'product' of the course was having an impact on practice there was a general view from both managers and practitioners that the 'new' Project 2000 practitioners and students had vast potential. However there was firm acknowledgement that such potential may be restricted or defused by the structural constraints of the health care service in the 1990's.

Project 2000 practitioners were described by one practitioner as the "head of the battering ram", this concept was supported by colleagues. Whilst a questioning approach was viewed as the "way of the future", the impact for change was seen as limited. This lack of being "hospital wise" was also picked up by the managers in centre 2. There was consensus that the students were vulnerable in their lack of 'realism'. The power of the 'sister' was still seen to be a force to reckon with (from senior sisters themselves). The students were perceived as having little management experience, although the ideas they held were considered of merit, the concern was the transforming of ideas into effective action, as the dialogue between three managers (Mental health, medical and gynaecological) in centre 2 illustrates :

> *I: "..Perhaps when they have done their management they will actually see that there are ward sisters around who are determined that is the way things will be done. They had not really got the insight into how they were going to implement change. Yes they had good ideas and when they are collectively on the wards as students they are full of lots of good ideas. When they are the one new staff nurse on the ward trying to implement that change, it is the realism again"*
> *D: "They are very vulnerable"*
> *H: "Yes, there are a lot of people around who would support them in changing practice but there are some people around who would try to block it, and they have not really quite grasped how they will go about it."* [p.28/29:S2/M/20.10]

The issue of 'fitting in' when in the clinical environment was acknowledged by the nurse teachers in centre 1, to be as prevalent today as in Melia's time (Melia 1987), with each ward / clinical area presenting another culture for the student to deal with, as the following conversation between a mental health and adult branch nurse teacher in centre 1 highlights:

> *A: "At one stage, I had a student. She was told she was asking too many questions, and she was not doing enough, so she thought 'Right, I will get down and just do, and she said, " Once I'd wound my neck in, I was accepted."*
> *K: "So is that a worry?"*
> *C: "They tend to confuse different cultures within different wards, but each new ward is different. Some of them have made the assumption that they go to the ward and they will be the same, but each ward is different."* [P.18/19:S1/NT/13.7]

Once again the concept of feeling responsible for 'nurturing' the diplomate and the student nurse was expressed but this time in the context of providing an environment where their "bright ideas" can be nourished and voiced with confidence. Once such confidence had been engendered they were perceived to have an inquisitive approach, as one manager in learning difficulties describes in centre 2:

> *"I do find them questioning a lot more - and the quality of the questioning is good- nursing models, philosophies."* [p.31:S2/M/20.10]

The big benefit seen by both practitioners and managers was the stimulus Project 2000 had on other trained staff. The preceptorship programme, when offered was seen to provide two way learning for both the diplomate and preceptor, with the latter forced to examine their own practice. The Project 2000 nurses were seen in both sites and by managers and practitioners alike to question what staff are doing and why. As one practitioner (dialysis) in centre 1 stated:

> *"We find that the Project 2000, as my colleague was saying, are not afraid to question ... there have been comments made about how much they do question. and that's the right thing to do."* [p.20/S1/P/7.12]

The positive effect that Project 2000 practitioners had in terms of encouraging research projects was also noted by managers and practitioners alike. Research study days attended by the students were seen to result in the sharing of research findings with interested staff. One psychiatric practitioner in centre 1, stated how the students often prepared a 'paradoxical' argument to explore alternative ways of care management. There was a general conclusion that:

> *F. "They are much more into research now."*
> *Z. "And they are much less afraid about actually saying 'Let me try to find something out.'* [p.20:S1/P/7.12]

> *Q. "They are far more research aware than we ever were when we qualified. [General agreement] I know it is from Day 1 they talk research - which then keeps all of us on our toes because we then have to be able to come up with the answers and show them where the research is."* [p10:S2/P/30.11]

This was seen by managers to have the same knock on effects of stimulating trained staff to do more research and set up projects and to actually work with the Project 2000 nurses. There was acknowledged to be a two way exchange of information, with the traditional staff having the practical skills and experience and the Project 2000 nurses with the experience of research and how to access literature. This combination, when working well, was seen to be an effective and stimulating blend.

The potential for change was seen to be there in the Project 2000 qualifier's ability and willingness to question and challenge even to the point of obstinacy. One medical manager in centre 2 states how :

> *"They will stand there far more and say that this is the correct way to do something and this is how we are going to do it. The world has to stop until then - do you know what I mean?"* [p.27/8:S2/M/20.10]

Practitioners did pose the question of where this change came from, was it because of their different education programme, was it because they now thought at a higher level or was it the changes that have occurred within the health service. The conclusion appeared to be a combination of all these factors producing a completely different culture.

There was an acknowledgement of all the changes that had happened synonymously with Project 2000. Whatever the ultimate cause, those completing the Project 2000 curriculum were seen to be more overtly questioning of nursing practise, and the way in which nursing care is delivered. It was acknowledged by several managers in centre 2, that perhaps traditional nurses were easier to deal with:

> *D: "Traditional are far more influenced by custom and practice, because that is how they were taught. They did not question. Obviously, we are making sweeping generalisations and of course many of them questioned things but nowhere near as much as Project 2000 trained nurses will question practice. They will question why you do what you do." [some omitted]*
> *H: " there were students from the traditional training who did question."*
> *D: "Yes. As I have said, it is a sweeping generalisation but they were usually suppressed in the main." [laughter]*
> *A: "They did it for a week! "*
> *H : "We soon sorted them out, didn't we?"* [p.4/5:S2/M/20.10]

Whenever change was mentioned there was inevitably the question posed of 'whether that can be placed at the door of Project 2000, or it is as a result of the changes within the health service? Despite the other changes occurring spontaneously with Project 2000, the latter was seen as having some responsibility for the continued evaluation of the care delivered. The outlook of the 'Project 2000' practitioners, in general was seen to be 'creative'. As one manager from Paediatrics (centre 1) comments in agreement, Project 2000 nurses appear to lack any fear in questioning established practice:

> *"The girls that I appoint have in fact improved [in paediatrics], I think - what is happening at ward level - because they do question practice and they are not frightened to question what somebody might have been doing for years. They will come on and say 'Why do you do it like that?' And even if they just want an answer to that question, it the trained staff question what they are doing. Certainly they have pushed things along."* [p.15:S1/M/5.10]

When the practitioners were asked if they saw Project 2000 qualifiers has having an effect on the way the multi-disciplinary team works, there was a consensus that yes they are and will continue to do so. This was partly put down to their views regarding 'consultants' and linked to their lack of being 'hospital wise', as several practitioners from centre 1 discuss:

> *S : "The consultants are not seen as gods. They don't treat them as gods, where the traditional nurse - if the consultant says that we must do it."*
> *R : "Jump, now."*
> *S: "Yes. Jump, you will jump. They will say, well, why should we jump ?"*
> *K: "Why do you think there is that difference ?"*
> *X: "Maybe because they have not spent three years on the wards " [laughter]*
> *Z :"They have a better academic base."* [p.21:S1/P/7.12]

Supernumerary status was seen to take some of the credit for no longer encasing the student within the norms of the working environment, where traditionally you were "taught to do as they do, you don't question". In comparison Project 2000 students were seen to be "brought up that you should question to find out if there are better ways of doing something" stated practitioners from centre 1:

> *R. "It was 'Look, listen, learn. Repeat" [Yes]*
> *C. "I think the Project 2000 find it harder to understand when you say I'm sorry, but my consultant says I've got to do it like this."*
> *M. "I found that hard! ' [General laughter]* [p.20/21:S1/P/7.12]

There was acceptance that the whole approach had changed and questioning was now in the curriculum. Although the Nurse lecturers were not asked directly whether Project 2000 was affecting practice, a similar issue emerged in the belief that the Project 2000 nurses are in general, more inquiring. A nurse teacher (adult) from centre 2 :

> *"One of the things which really struck me about this 'new animal', is that they are more inquiring "* [p3:S2/NT/1.6]

There was concern that their desire and ability to question would be affected by the pressures to conform upon qualification. As mentioned earlier, concerning the issue of the relative security of being in a crowd of students, as opposed to being a diplomate nurse within an established team, there was a fear that once they became qualified they may well fall into the role of the 'old system'. Questioning was seen to be the way forward if progress and change was to be implemented and nursing was to become a stronger profession, as one practitioner from gynaecology in centre 2 stated:

> *"as far as the medical staff are concerned, the nurses do give their views and do not stand back. As students they do and I hope that they do keep that up when they qualify. It is so easy to fall back into what everybody else is doing and not question it."* [p9:S2/P/30.11]

The nurse teachers however, accepted that each student was of course an individual and that many choose to simply 'survive':

> *G: "I think it was the point I made before that students are different, each student is different and I think there are many students who simply, in order to survive, adopt the attitude that is prevalent on the ward, who never intended to become a challenger. I would certainly agree that at the end of the course, students would tend to be very similar but the course does offer a chance for students who want to go beyond that, to do more, to develop more. That was never there in the past."*
> *D: "No".*
> *G: "There was a very basic standard and everybody reached that standard. There is hope now for students to progress."* [p.21:S2/NT/13.7]

The Advocacy Role

The nurse as patient advocate was seen by practitioners as an additional role for most nurses in centres 1 and 2. This newly acquired role was seen to be of great importance, across all the branch programmes and between hospital and community care. One impressive outcome of the Project 2000 curriculum and experience was seen to be the notion of advocacy generated. The Project 2000 students and qualifiers were perceived in general to take advocacy seriously, and have an ability to stand up for the patients' rights. This was seen by practitioners as a major change from the traditional stance where it was left up to the sister, or at least the staff nurse to disagree with the consultant, as two practitioners from two different surgical areas agreed :

> ***C.*** *"the actual nurse will actually say 'Hang on a minute, stop what you are doing. Can I just say that Mrs Such-and-such doesn't want that amputation. She doesn't want it.' The patient is sitting in the bed absolutely in tears but the nurse will say."*
> ***S.*** *"That is good."* [p.32:S1/P/7.12]

This was confirmed by the managers who saw the Project 2000 students as more ready to question practice and the traditional way of doing things. They perceived them as better equipped in a short space of time, than the traditional students, to become patient advocates in a meaningful way. This is seen as a product of the new approach to education, as described by one medical manager in centre 2:

> *"the fact that they simply were not trained in the same way. It is not an apprenticeship system where you do as you are told in quite that same traditional way, as it was when we trained.[agree] I am not saying that they never questioned - of course they did - but in the main, you tend to get far more lively responses from the Project 2000 students if they come up against something with which they disagree strongly."* [p.6/7:S2/M/20.10]

The concept of patient advocacy was also seen to be facilitated by the new organisation of care. Nurses are now seen more as individual practitioners, compared to the 1980's when the sister / charge nurse took responsibility for all the doctors rounds and decisions made while merely passing on the work needing to be done to the junior staff. Now with primary nursing, the named nurse and smaller team working, nurses were seen to take greater responsibility for patient care and the appropriate decision making.

Educationalists from centre 1 were perhaps more cautious in their conclusion regarding the ability for Project 2000 practitioners to establish change and progress. There was a fear that the new practitioner may well accept the status quo in the longer term, this was seen as the 'real test' of success for the new curriculum. Teachers, managers and practitioners all suggested that within the present 'climate of conflict' expectations may be too high for the Project 2000 qualifier. Here again continuing education was seen as having a vital role to play, if the gains of Project 2000 were not to be lost.

Section Summary

Managers, practitioners and educationalists all felt that the Project 2000 practitioner had great potential as a professional practitioner. The need for support and supervision was a recurring theme together with a review of what could reasonably be expected of a newly qualified nurse in terms of initial skills. The potential of the Project 2000 nurses as change agent was also acknowledged. There was clear consensus between teachers, managers and practitioners that the Project 2000 qualifier needed a period of post-registration consolidation to maximise their educational process and professional abilities. Both groups once again felt constrained in their ability to provide the desired level of support and supervision. One particularly vulnerable area needing supervision and support was that of night duty. The diplomate was seen to be in need of additional preparation if such posts were to be taken up with confidence.

The diplomates were perceived by all participants to have vast potential, but they felt that this potential may be constrained by structural constraints within the health service of the 1990's. The diplomates were perceived to be more prepared to challenge practice and question others, and this was acknowledged to facilitate reflection on practice by their colleagues. The practitioners and managers felt that it was important that this approach was supported by providing an environment where their ideas could flourish. Diplomates were felt to view doctors differently, they were no longer' gods' to be revered, but colleagues who could be questioned and challenged. Advocacy was felt to be an important development, with diplomates taking their role within this very seriously. There was general concern however that continuing professional education (CPE) must be facilitated if the gains of Project 2000 were not be lost.

5. 4. THE TEACHERS', MANAGERS' AND PRACTITIONERS' TALE: OVERALL SUMMARY

From an analysis of the focus group data it can be seen that perceptions of nursing had shifted for teachers, practitioners and managers. This was felt to have been facilitated by their exposure to further education, which included to some extent involvement with the Project 2000 curriculum. Participants also felt that the students perceptions of nursing changed towards a 'new ideology' as the course progressed. Within the 'new ideology' of contemporary nursing the patient was perceived to take a central place. The nurse's role was seen by teachers, managers and practitioners to take on a much broader dimension, encompassing activities of co-ordination and patient advocate. Basic nursing care and 'bedside nursing' were also perceived to be valued by the students, and focus group participants alike. Patient expectations were also seen to affect perceptions of the philosophy and practice of nursing, with the increased demands for informed choice. Teachers, practitioners and managers saw potential conflicts created when the emerging 'ideology' of current nursing meets the financially driven demands for a 'cost effective service'. Within this the issue of the increasing need to justify the nurses role and their impact upon patient care was central. Resource implications were seen to have detrimental effects on student and diplomate learning and support. Resources for CPE were seen to be essential if the gains of Project 2000 were not to be lost.

Overall the managers and practitioners were pleased with the 'products' of the course, and were keen to employ the diplomates. The impact of the Project 2000 practitioner was described in terms of their 'potential for change', rather than the achieved reality. Students and diplomates alike were perceived to offer opportunities as change-agents with the questioning and challenging approach they brought to practice. Managers and practitioners acknowledged that the course had provided a two way learning process. Traditional practitioners were seen to be sharing their experientially gained expertise, and the Project 2000 practitioners their theoretical knowledge, including research and a critical approach to care. The acquisition of a diploma qualification by Project 2000 students was seen to motivate traditional staff to seek further academic qualifications. Moreover, the Project 2000 students' 'distanced' position from the service provision meant that they were seen to 'challenge' traditional approaches to care, and the hierarchical structure supporting it.

The initial practical skill deficit was discussed at length within the focus groups, and practitioners and managers requested a greater input of these skills within the Project 2000 programme. The issue of support and supervision was discussed at length, with managers in particular suggesting they were failing both students and newly qualified diplomates at the supervisory level due to financial constraints. However, it was generally concluded by all participants that expectations placed upon newly qualified nurses have always been unreasonably high and it was felt that these need to be revisited. One exception was that of the specialist areas, who have always faced the necessity of providing post-registration preceptorship for a specialised role.

The role of the Project 2000 diplomates within the community nursing service provoked interesting debates. It was felt that it was easier for the newly qualified Project 2000 nurses to be accommodated within the district nursing service rather than the health visiting service. Within the former there already existed staff nurse posts whereas it appeared more difficult to create the structure within the health visiting service. Generally practitioners and managers felt that the Project 2000 programme offered a good preparation for the community. However, these data appear to suggest that the diplomates are currently not able to go straight into the community nursing service upon qualification, as the existing structure does not accommodate them.

Chapter 6: Discussion

INTRODUCTION

This study set out to examine a new era in nurse education with a set of aims and objectives designed to answer the central research question. That is to what extent have there been changes in the perceptions of the philosophy and practice of nursing consequent upon the implementation of Project 2000. From the data presented in the preceding chapters there would appear to have been a fundamental shift in perceptions of the nature and discipline of nursing, but before these are discussed it is necessary to place such changes firmly in context. The data also suggest that there are some consistent issues with pre-Project 2000 nursing and nurse education and these are presented before the implications for nursing and nurse education are discussed. The issues arising from the research are therefore discussed in this chapter under the following headings:

1. **Context**
2. **Shifting Perceptions: A New Practitioner?**
3. **Consistency: Some Things Never Change**
4. **Implications for Nurse Education and Nursing**
5. **Conclusion**

6. 1. CONTEXT

Project 2000 has been implemented at a time of unprecedented change in both nursing education and more broadly the NHS. At the macro level the UK has been faced with consequent impact on workforce and resources. In the health service the NHS reforms (D of H 1989a) have resulted in the purchaser provider split in health care provision, this has had implications for the role of nursing with nurses tailoring their work to the requirements of purchasers. The community care act (D of H 1990) has also changed the role of nurses in the mental health and learning disability fields and has wider ramifications for all nurses. The reduction in junior doctors hours has also affected nurses work, generating a debate within the profession on the extended role of the nurse.

Within nurse education itself, at a micro level, there have been fundamental changes over and above the introduction of Project 2000. Pre-registration nurse education is now a diploma level curriculum and is taught in institutions of higher education. Nurse teachers have been under immense pressures resulting from the move to an all degree work force, and the move into higher education. The latter has resulted in amalgamations of colleges of nursing over a number of years and has led to uncertainty, redundancy and insecurity for all concerned. The effects of the speed of introduction of the Project 2000 programmes is well documented elsewhere (Elkan & Robinson 1991, Jowett et al 1994), but the effects of the whole shake-up of nurse education on nursing is harder to identify. This would include the introduction of PREP and Framework, Higher award programmes, and the general move into higher education with all the changes of culture and methods that has entailed. The Project 2000 programme can therefore be seen as just one, albeit very significant change in a plethora of changes facing nursing and nurses in the 1990's. The changes identified in the following sections therefore need to be continually viewed with these contextual issues in mind.

6. 2. SHIFTING PERCEPTIONS: A NEW PRACTITIONER?

The findings presented in the preceding chapters appear to suggest that a "different" type of nurse from those described in earlier studies of traditionally prepared nurses of a decade ago (Gerrish 1986, Henderson 1966, Melia 1987) is emerging. This is in keeping with the findings from other studies of Project 2000 nurses (Jowett et al 1994, Jonas 1993). It is important to note here however that to dichotomise between Project 2000 prepared nurses and 'traditionally' prepared nurses is somewhat artificial. The introduction of the concepts inherent in Project 2000 has been an evolutionary process and as noted earlier has had a 'knock-on' effect on the learning of other nurses. Indeed the majority of the Project 2000 diplomates in this study did not perceive themselves as 'different' to their 'traditional' colleagues. Shifts in the perceptions of the nature and discipline of nursing can be noted when compared with studies of a decade or so ago however the above caveat needs to be borne in mind throughout this chapter.

One of the aims of Project 2000 was to produce a nurse capable of reacting to the changing needs of health care into the twenty first century. This new practitioner should be a 'knowledgeable doer', with research based practice, and a sound rationale for the care given (UKCC 1986). In this study it would appear that these aims are well on their way to being realised. There has been a shift in perspective away from the 'traditional' view of nursing, towards a more patient centred, research based practitioner, prepared to question colleagues and act as the patients' advocate. This 'new' nurse has theoretical knowledge at her fingertips, and views the patient holistically in the context of his environment and personal circumstances. They are health promoters in the broadest sense, with health promotion embedded in care delivery. Academic and professional development are important to the Project 2000 nurses, and there appears to be a commitment to lifelong learning, but the central focus of their role is the provision of research based quality care for the benefit of the patient.

The Knowledgeable Doer

The findings strongly suggest that Project 2000 students increasingly valued their theoretical knowledge as the course progressed. Once qualified, the diplomates had both theoretical and research based knowledge and did not perceive their education to be a 'once and for all' activity. Rather they were keen to continue learning and to top up their diploma to a degree. By contrast the newly qualified 'traditional' staff nurses interviewed by Gerrish (1986) lacked the theoretical grounding on which to base their patient care decisions. Indeed one of the difficulties encountered by these staff nurses was in deciding when to contact medical staff about a patients' condition (Gerrish 1986). They were concerned that they often did this for trivial reasons and coped by a process of trial and error, assessing the doctors' reaction. Gerrish concludes: "the staff nurse appeared not so much to base her decision on her theoretical knowledge of the patient's condition

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but rather on the reaction of her medical colleagues; a major barrier to any claim for professional autonomy" (page 96). The managers and practitioners also perceived the increased theoretical base of the students and diplomates and identified the benefits to the profession as a whole and to patient care.

The students at the beginning of the course identified a lack of exposure to practice as a weakness of the Project 2000 programme. As the course progressed, this was identified less frequently, and the diplomates stated that it was an initial skills deficit only. The managers and practitioners also confirmed this, suggesting the diplomates made up the skills deficit within the first few months. They were then perceived to be more flexible and knowledgeable practitioners, which the managers and practitioners were keen to employ.

The depth and breadth of theoretical knowledge together with the assertiveness training from the course, appeared to allow the diplomates to feel comfortable in saying when they did not know how to do something rather than forging ahead on a trial and error basis, as had been the practice in the past (Gerrish 1986). Jowett et al (1994) reported similar findings from their study: "the students showed a substantial degree of confidence in their ability to rise to the challenge and were expecting to learn a great deal and to feel comfortable about asking in the workplace. As one of them elaborated: "I think Project 2000 people may be less afraid of saying that they don't know something" (page 101). This has been conceptualised in this study as "no bluffing" and was also an aspect of the patient centred approach to care where diplomates would not jeopardise patient care or safety, and took accountability very seriously.

The Patient Comes First

In keeping with this view of themselves as independent autonomous practitioners together with their increased knowledge base, the diplomates strived for a new way of working which put the patient at the centre of care and brushed aside the routinised often ritualised practices of the past. In contrast, Gerrish (1986) found that her interviewees were keen to learn the routines in the absence of any other basis for their care, and copied what others had done the day before as a way of coping ("fumbling along"). Melia (1987) identified a tendency for the students in her study to 'get though the work' at all costs. This was frequently linked to the routine of the practice environment, and there was often an amount of work to be got through before a certain time. As she suggests: "If nursing is conceived of in these terms it rapidly becomes an activity divorced from the care of patients" (Melia 1987 page 46).

The students and diplomates interviewed in this study seemed more able to hold onto the nursing values as taught in college by putting the patient first at all times. The move away from an apprentice service orientated style training towards a more professional model based in a higher education institution may have facilitated a different socialisation process which may help explain these differences. It could be argued that the students gained their vision of nursing primarily from the Project 2000 course. On entry to the programme the majority of students perceived nursing in fairly narrow bio-medical or lay terms. Many students subsequently commented on the breadth and scope of nursing as taught by the course. This deeper view included holism, research based care and a broader theoretical base. This study has clearly demonstrated the changes in students' perceptions over time, and although the wider context needs to be borne in mind, it is possible to identify the Project 2000 course as one of the fundamental influences upon the students' perceptions of nursing. It is not possible to determine from the present study whether these views are maintained once the students are qualified and in the practice environment for any length of time. Further research in this area is both desirable and necessary.

The Project 2000 students and newly qualified diplomates have found themselves at the centre of an increasingly complex system of health care delivery. On the one hand they are more patient focused than their traditional colleagues and are keen to act as patient advocates (Jowett et al 1994) . Yet on the other hand they face increasing pressures from a more knowledgeable and articulate public. Social changes and the patients' charter have ensured that nurses must be both up dated and accountable for their practice. Both are added pressures and are difficulties that their traditional colleagues did not articulate (Gerrish 1986, Melia 1987, Humphries 1987). The diplomates in this study took their responsibility and accountability very seriously and the increase in litigation in recent years has only served to heighten their anxiety in this area. Litigation was not mentioned in previous studies (Gerrish 1986, Melia 1987, Humphries 1987). Structural constraints and lack of resources hindered the staff nurses being able to practice as they had been educated to do. In the qualified diplomates questionnaire data, respondents suggested that lack of staff and lack of time prevented the diplomates meeting their nursing priorities. In the last decade patient stays have decreased dramatically whilst the number of operations performed and the use of technology has risen (Audit Commission 1995). Yet the nature of the support available to newly qualified staff nurses remains as poor as ever. This together with the clash of cultures demonstrated by the theory practice gap is examined in the following section.

6. 3. CONSISTENCY: SOME THINGS NEVER CHANGE

"Cast Adrift". The Issue Of Support For Newly Qualified Staff Nurses

One of the more striking issues to emerge from the data was the lack of support available to the new diplomates. Lamentably however, this is not a new issue. It has long been realised that a programme of support may facilitate the transition process (Kramer 1974, Shand 1987, Lathlean et al 1986). Indeed it has more recently been recognised by the UK regulatory body, the UKCC. They have suggested that support and guidance should be available for a period of approximately four months to all newly qualified staff nurses in the form of preceptorship (UKCC 1993). It would appear from this and other studies (for example: Jowett 1995) that this has not been realised.

Some authors have suggested that a preceptorship programme does not aid the qualified nurses socialisation process (Itano et al 1987) or produce any significant difference in the clinical skills of preceptored and non-preceptored nurses (Huber 1981, Myrick 1986). Morton-Cooper and Palmer (1993) however suggest that any evaluation of preceptorship must be certain in its aims. They suggest some of the preceptorship evaluations have been unclear in the specific aspect of preceptorship being evaluated. They have argued effectively in their work that preceptorship is both fundamental to the transition process and long overdue in the UK. They suggest that the strengths of preceptorship lie in "enabling practitioners to develop their knowledge and skills in an atmosphere of trust, with colleagues who have experienced it for themselves, and who have been prepared for and understand the challenges confronting the beginning practitioner" (page 100).

The diplomates in this study who had received preceptorship had found it extremely valuable and all interviewees felt that it would have been helpful, even when they had not experienced it. Allen (1993) has also suggested that a period of preceptorship is valuable. Having experienced a particularly supportive preceptorship herself with consistent and clear boundaries she suggests this has enabled her to "push the boundaries of community nursing and to think radically about what it is that district nurses do" (Allen 1993 page 60). In a small study Maben (1995) has suggested that a period of preceptorship appears to ease the transition from student to staff nurse for those diplomates who experience it. Robinson et al (1993) suggest that new staff nurses need "a period of time in practice to consolidate what they have learned and gain confidence with the support and guidance of a skilled and experienced mentor" (page 34). They go on to recommend a development programme whereby for the first three months at least, the new staff nurse should not be left in charge, and during which time skilled mentorship should be available. It is perhaps lamentable that the UKCC have not made preceptorship mandatory, but more importantly what is required is a recognition and commitment from the profession that preceptorship is both desirable and necessary. For as Jowett points out "creating a structure without securing staff commitment was not of benefit to the recipients" (Jowett 1995 page 6). Indeed Robinson et al (1993) recommend the need for further education and support for the preceptors of the newly qualified diplomates themselves. Describing the clinical support available to Project 2000 students in the form of mentorship Wilson-Barnett et al (1995), reflecting findings from the White et al study, suggest that an understanding of this complex issue requires examination of the broader clinical environment. Students identified staff committed to teaching, a good team spirit and practitioners with time to give students as factors facilitating good learning. Teachers in the study added that being encouraged to ask questions, a lack of hierarchy in the team, and staff with a positive view of Project 2000 were also important (Wilson-Barnett et al 1995).

For the full potential of the Project 2000 diplomates to be reached it is necessary to think about creating an environment ready to receive them and ready to utilise their skills to the full. Ryan (1989) has proposed a "support hierarchy" model rather than the current command hierarchy as best accommodating the needs of Project 2000 students and diplomates, and most beneficial to patients. He has argued convincingly that in many ways Project 2000 has been constructed "back to front". He suggests that "the students have been given the function of educating the clinical areas; rather than the clinical areas being enabled to prepare students for a new model of practice" (page 1). The support hierarchy model facilitates a patient centred approach to care. He suggests that with the patient at the apex, the relationships between all the primary carers e.g. family, nurse, doctor etc. is a collegial one, with each supporting the other. This is appealing as a model of organisation, but requires some fundamental changes in the whole health care system for it to function effectively.

The support received or not received in the transition period is crucial to the future of nursing as the first six to twelve months may set the staff nurses pattern of future practice. If she is not well supported and well received she may either abandon the questioning approach gained on the course and 'fit in' or may chose to leave nursing altogether ('Withdrawal' category in Kramer 1974). Either of these options would appear to be undesirable for the nursing profession.

The diplomates in this study suggested that a supportive environment included not only preceptorship, but forward thinking dynamic staff. This was felt to be an especially important quality in the ward sister/manager whose position of authority ensured the ability to change practice and implement new ideas. The importance of the role of the ward sister in facilitating a learning environment has long been recognised (Orton 1981, Fretwell 1982, Pembrey 1982). Together with more senior managers, ward sisters have a responsibility to the new diplomates in attempting to facilitate an easier transition process. It is recognised that this may not always be possible where resources are tight and may require a redefinition of priorities in certain areas. It was also felt to be important by the diplomates in this study that staff respected and trusted them, and gave them appropriate responsibility. A forum for discussion and regular feedback from colleagues was also seen as a vital part of a generally supportive environment.

It may also be necessary to re-evaluate or re-consider what constitutes a realistic expectation of a newly qualified nurse. The UKCC (1986) called for an end to the "old tradition of a once and for all training, encyclopaedic in its objectives". The diplomates themselves had a realistic expectation of their preparedness, as did those in other studies (Jowett et al 1994). It may require some adjustment on the part of their colleagues and managers however. It is important to recognise that the practitioners interviewed in this study *are* 'different', as outlined above. In fact they appear quite remarkable in the face of unyielding expectations and at times open hostility. They posses a wide range of skills, and any practical skills deficit is a short term problem only. This is due for the most part to their own determination, and ability to grasp things quickly rather than any extra support or preceptorship, which was not experienced by the majority. The difficulties reported in adjusting to the staff nurse role are not new (Vaughan 1980, Gerrish 1986, Humphries 1987), but a more novel approach would be to suggest that to adopt immediate responsibility and accountability without any support is an unrealistic expectation of a newly qualified nurse. Indeed part of a wider support process would be to become more realistic about what neophyte nurses can realistically be expected to do. As managers in specialised areas are already realising, the days of being able to take them off the shelf and use them on day one have gone. Every area, not just the specialised areas need to realise that the newly qualified nurse needs a nurse programme after qualification. A re-evaluation of expectations together with a programme of support would go a long way to easing the transition process.

Clash Of Cultures: The Theory / Practice Gap

Respondents expressed concern however as to whether the 'new' nursing ideology fits with the realities of practice. Across most of the focus groups, issues emerged which reflected the clash of cultures between the new ethos represented by Project 2000, and the need to meet the demands of practice which had changed as a result of the NHS reforms.

It was acknowledged in both centres that government targets and policies were affecting the perceptions of nursing. There is now a general ethos towards health promotion rather than merely nursing the sick, this was fostered by policy documents such as the 'Health of the Nation' (D of H 1992), where individual responsibility for health was seen as important and now emphasised. The changes perceived in nursing were not solely placed at the door of Project 2000, it was seen as part of the whole 'process' of change and the domino effect. The change in nursing itself was represented by the changes in the delivery of care as a result of financial pressures and government policy, such as the 'patients charter' (HMSO 1992) forcing a change in patient trajectories. Expectations of care from a nursing perspective have changed, in the sense that practitioners no longer aim for a 'total cure' prior to discharge, but aim to deal with the acute stage in hospital and then pass them onto the community services. These pressures upon the nurse in the reality of the practice environment appear to compete with the perceived 'patient centredness' of the Project 2000 nurses and with the ideals of our focus group respondents. Indeed there may be a tension for the students and diplomates between holding onto their beliefs and values gained from the course, and often appearing "different" to colleagues or compromising their view of nursing in an attempt to 'fit in' and be accepted in the workplace. Ryan (1989) has suggested of Project 2000 that "as a strategy for change it gives the greatest responsibility to the weakest and most inexperienced group" (page 15). At present he would suggest that it only endows learners with everything they need to fit in with present practice except the capacity to change it.

There are similarities here with other studies which have examined the transition of the traditional student to the staff nurse role. Gerrish (1986) suggested that for her interviewees there was difficulty in relating theory to practice in some settings and Bendall (1975) suggested that this is because of a dichotomy between school and practice. Melia's (1987) interviews with 'traditional' student nurses also established this dichotomy between the nursing as taught in college and that experienced in practice on the wards. Indeed the students interviewed recognised the differences and established ways of negotiating the gap. "The students, on their own admission, learnt to 'fit in' with whatever seemed to be expedient at the time. Their main concern was to meet the expectations of those with whom they worked especially those in authority" (Melia 1987 page 141). The findings from this study also identified some resistance to change from existing nurses, resulting in problems for the Project 2000 students and diplomates. Robinson (1991a) has suggested that any resistance to Project 2000 should be seen as an adaptive function and as precursor to professional growth. She suggests that where resistance occurs it should not necessarily be seen as a negative force, but rather as a means of coping with rapid change. There is no doubt that the impetus and force of change has been at times overwhelming for nurses, but it is also difficult for the Project 2000 students and diplomates to meet resistance to their ideas, and at times stigma for what they represent.

This perceived gap between theory and practice is in keeping with Kramer's findings and the gulf between college and practice nursing values represents a large part of the 'reality shock' she described (Kramer 1974). She suggested that the nurses education had been based on the professional model with an holistic approach to patient care. However upon qualification they found themselves working in practice environments where a bureaucratic model existed. Once in this work situation they were susceptible to losing their college bred values and succumbing to the influence of the work culture. It is possible however to discuss further the practice environment in which the diplomates found themselves. Those that have dynamic forward thinking staff, who are open to question, are able to put into practice their Project 2000 principles of nursing, which reduces any tension between theory and practice and eases their transition process. For others colleagues' resistance to change as discussed above represents a major stumbling block.

Central to the theory practice debate was the practice role of nurse teachers. This emerged as an area of concern for nurse teachers, practitioners and managers. There was much debate in the focus groups on the issue of whose responsibility it was to teach the practical skills to the students. The general agreement was that it was the role of the practitioners facilitated and supported in their academic development by the teachers. Several role models were discussed and explored including that of link lecturer, lecturer-practitioner and practitioner-lecturer. It is interesting to see that this debate remains alive and well within nursing, and it would seem important for more research on this important area to be undertaken.

6. 4. IMPLICATIONS FOR NURSE EDUCATION AND NURSING

This study has demonstrated that a 'new' practitioner, able to plan effective care based on research with the patient as a priority at all times is perceived to be emerging from the Project 2000 course. However, there are a number of issues arising from the case studies which have implications for nursing, and nurse education in particular, which warrant special attention. These include the theory practice gap and the issue of support and preceptorship in the practice environments as discussed above. They also include health promotion, practical skills and life sciences deficits, lifelong learning and the preparation provided by the Project 2000 course for community practice. Discussion of these issues are presented under the following four subheadings:

1. **Health Promotion**
2. **The Swinging Pendulum: The Balance of Project 2000 Courses**
3. **Lifelong Learning and Support**
4. **Preparation for a Role in the Community**

Health Promotion

The Project 2000 course has an emphasis on health as well as ill health and aims to produce nurses equipped to be health promoters. This study has demonstrated that students and diplomates are confused about the meanings of the terms health education and health promotion. This is not new, previous studies have demonstrated 'traditional' nurses' poor understanding of the concepts (Latter 1995, Macleod Clark et al 1992, Gott and O'Brien 1990). However, the students and diplomates did demonstrate a broader understanding of the determinants of health including socio-economic and environmental factors. This was generally not conceptualised as health promotion but rather was seen as a facet of holism. Health education and health promotion were generally conceptualised as lifestyle related and tended towards the individualistic victim blaming approaches now discredited by most health promotion theorists (for example Tones et al 1990). The wider political and economic aspects were largely absent from any definitions of health promotion, and whilst these may have been included under the holism label, the potential for nurses to be more active politically was not. For nurses to fully appreciate their role as health promoters they need to be aware of the full health promotion picture. This would include empowerment, and the potential for socio-political action, (for example making the healthy choice the easy choice). Understanding the socio-economic determinants of health via holism, may only lead to frustration for nurses who have not been equipped or taught the empowerment and political lobbying aspects of health promotion. It has been suggested elsewhere that health education and health promotion is poorly understood and poorly taught (Macleod Clark et al 1992), and indeed a more recent report has confirmed this (Lask et al 1994). Effective teaching of this important issue is crucial if nurses are to reach their full potential as promoters of health.

The Swinging Pendulum: The Balance Of The Project 2000 Course

It has been suggested by some of the participants in this study that the nurse education pendulum has swung too far towards the pure disciplines of sociology and psychology to the detriment of nursing. It was acknowledged that there is much to commend the Project 2000 course, and indeed students and focus group participants alike welcomed the sociology and psychology input, but would rather have had a little less pure sociology and psychology and a little more life sciences and practical skill acquisition. The Project 2000 course was hailed as an improvement by the majority of those who had experience of 'traditional' nurse education, and no-one wanted to see the clock turned back. There was a general feeling however, that the course lacked balance, and several suggestions were made for improvement. These included a greater emphasis on the biological and life sciences, and either a reduction in the length of the common foundation programme or more commonalty for all branch programmes. The numerically smaller branches (mental health, learning disability and child) suggested that the CFP had an adult bias, which resulted in a perception that their course only commenced after eighteen months. The management preparation on the course was described by diplomates as 'hit and miss' with experiences varying between practice areas. It was suggested that more management input with practical application would be helpful together with a greater degree of standardisation.

It has been emphasised that the practical skills deficit is an initial deficit only, and that once in the practice environment as a qualified nurse any deficits are quickly made up. However, there was a feeling that it would reduce a great deal of stress for both students and practitioners if they could feel a little more confident in some of the very basic aspects of nursing care at an earlier stage in the course. Students who had not been taught how to make a bed felt disadvantaged and helpless in the practice environments, which did not help relationships with colleagues. Students were also keen to experience practice earlier in the course, and this has been addressed to some extent in the new curriculums in each of the study centres. As suggested earlier there may also be a need for existing practitioners to re-appraise their expectations of students and diplomates in particular. Comparisons with 'traditional' students were not helpful and although the incidence of overt comparisons was reported to be declining, they were none the less keenly felt by the Project 2000 students. Clearly the suggestions for modification of the course was not a plea for a return to an apprentice style situation, or for students to be included in service provision rather a concern that in re-defining nurse education the pendulum had swung a little too far the other way.

Lifelong Learning and Support

The issue of preceptorship and support for the newly qualified diplomates has been discussed above. However, one particular aspect of this support is noteworthy. That is the support for continuing professional education (CPE). The data in this study demonstrate the commitment to 'lifelong learning' of the Project 2000 diplomates. The majority were very clear about their career trajectories and intentions at two and five years post qualification. There was an overwhelming commitment to continuing professional education within these intentions. However, both the practitioners and managers in the focus groups and the Project 2000 diplomates themselves cited a lack of resources and underfunding as a barrier to continuing education. A recent study (Hogston 1995) has demonstrated the real impact that CPE and knowledge have on professional competence and the quality of patient care. The author concludes "The process of CPE was identified as a fundamental component of providing quality nursing care but nurses readily identified the factors which may hinder them from reaching their full potential. These included financial restrictions and a reluctance by managers to fund courses they perceive to be irrelevant" (page 592). One of the fundamental aims of Project 2000 was to engender a commitment to lifelong learning and continuing professional education. Indeed a great deal of energy has been invested in both Project 2000 and the commitment to lifelong learning. It would then be a travesty if a similar investment were not forthcoming for CPE.

Preparation For A Role In The Community

Another of the aims of the Project 2000 course was to prepare students to practice in the community setting. It would appear from this study that this aim is far from being realised. Few of the diplomates were able to secure a community nursing post despite wishing to do so. There appears to be a degree of resistance to this from existing community practitioners who are understandably attempting to protect their positions. The focus group data highlighted the issue of skill mix and the lack of any pre-determined structure in the community to incorporate the newly qualified diplomates. Their link into the community remained ill defined. The course was seen to facilitate a community orientated practitioner with its emphasis on health as opposed to illness, and its holistic focus enabling students to view patients as part of a wider community. However, some feared the greater emphasis on the community disadvantaged students in acquiring skills needed for hospital settings. Others suggested that students would still need to gain hospital experience as a qualified nurse prior to commencing a community nursing post. A district nursing post was perceived as a more viable option for the students as there was already community staff nurse posts within the district nursing service. The role of the new diplomates within the health visiting service was perceived as more problematic, with there currently being no recognised staff nurse posts supporting health visitors. This is an issue that requires debate at a wider level and would benefit from further study.

6. 5. CONCLUSION

This study is one of the first to examine the perceptions of the experiences of the Project 2000 students and diplomates. Several issues arise from the findings which emphasise a shift in the nature and discipline of nursing and the Project 2000 course is clearly one of the important factors in this. The Project 2000 students and diplomates placed the patient firmly at the centre of care delivery. They viewed the patient holistically, were often fierce patient advocates and were keen to utilise research in the practice environment. They valued basic nursing care and the communication skills they had been taught in college. There was an initial practical skills deficit but this was an initial deficit only and was made up by six months post registration. The students and diplomates were analytical and questioning and were committed to lifelong learning. The wider contextual issues at a time of unprecedented change also need to be taken into consideration. In other areas there are also clear consistencies between the experiences of Project 2000 students and qualifiers and 'traditionally' trained nurses. The most striking of these is the issue of lack of support for neophyte nurses and the theory practice gap which appears to remain alive and well.

The issue of support and preceptorship in particular has been explored as a model for easing the transition process. Implicit in the identification of a supportive environment is that these factors would facilitate post-registration development of nursing practice, would help retain new diplomates in practice and would ultimately improve patient care. A dynamic, non-hierarchical supportive environment has been found to be an important factor in facilitating the health education and health promotion role of the nurse in acute settings (Macleod Clark et al 1992) and in facilitating learning (Wilson-Barnett et al 1995). It may also be of benefit in facilitating the transition process. The expectations of what preparedness for practice really means has been questioned, and research into the trajectory of the initial skills deficit and the practice environment would aid further understanding.

Other issues important for nurse education and nursing include the teaching of the concept of health promotion, the importance of addressing the balance in the course, particularly with respect to life sciences, preparation for a management role and practical skills, and the role of the Project 2000 diplomate in the community.

In conclusion this study has both confirmed the findings from other studies and raised new issues and questions concerning the experiences of students and newly qualified diplomates. Further research in this area is needed to determine the effects of the practice environment on the transition process of newly qualified diplomates, on the effects of a comprehensive preceptorship programme and in tracking the skills development of the new diplomates. This is to be recommended for the individual students and newly qualified nurses, for the profession as a whole and ultimately for the benefit of patients.

APPENDICES

APPENDIX 1

Centre 1 Course Outline

MODULAR ORGANISATION OF CFP AND BRANCH PROGRAMMES

COMMON FOUNDATION PROGRAMME

1	2	3	4	5	6	7	8

BRANCH PROGRAMMES

<——DEVELOPMENTAL STAGE—— <CONSOL>

9C	10C	11C	12C	13C	14C	CHILD CARE (C)

<-----DEV STAGE---->- <CONSOL STAGE ------>

9A	10A	11A	12A	13A	14A	ADULT CARE (A)

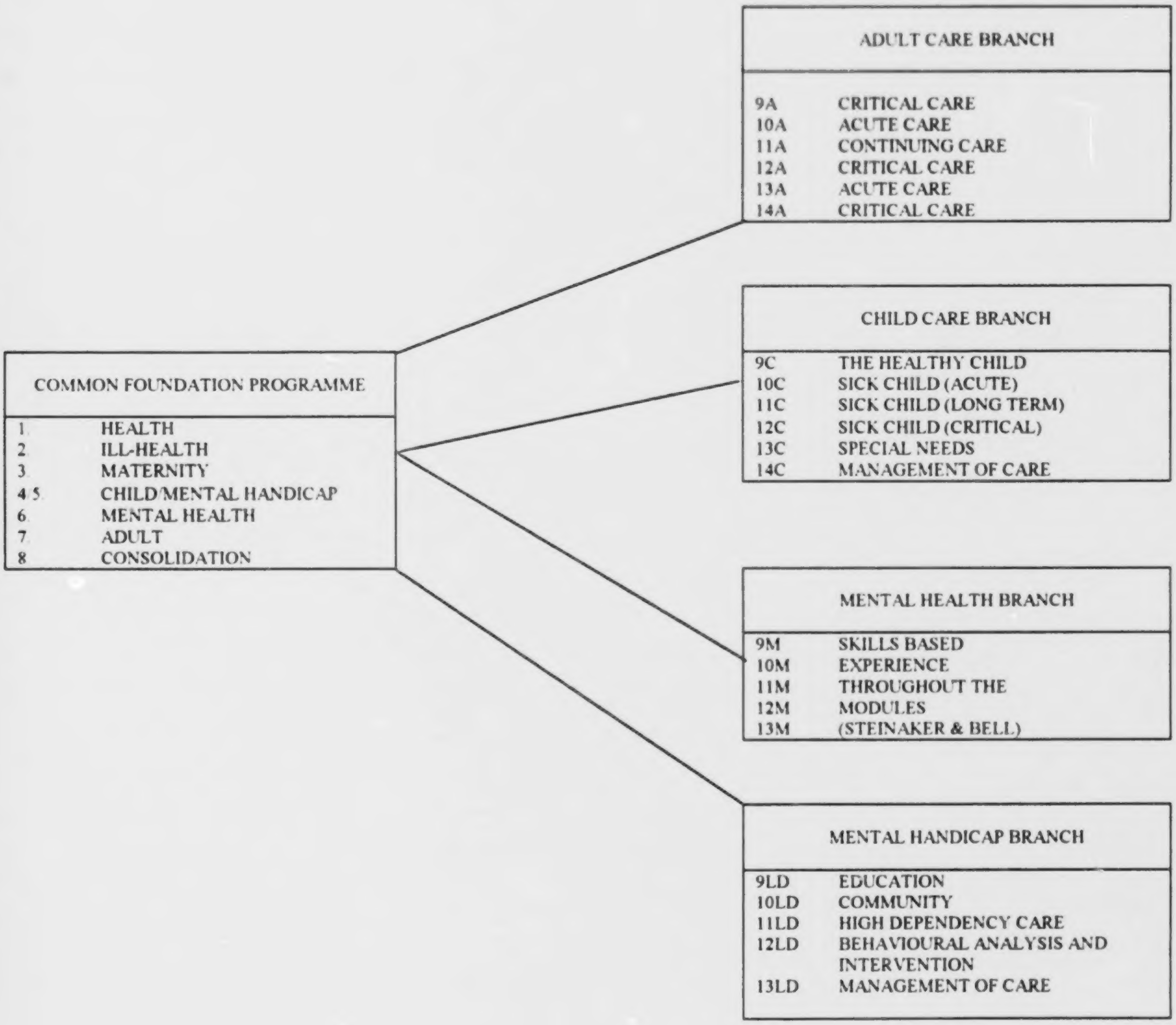
<----DEV STAGE---><----CONSOL STAGE ---->

9M	10M	11M	12M	13M	MENTAL HEALTH (M)

<----DEV STAGE---><----CONSOL STAGE ---->

9LD	10LD	11LD	12LD	13LD	MENTAL HANDICAP (LD)

DIAGRAM 2



COMMON FOUNDATION PROGRAMME	
1.	HEALTH
2.	ILL-HEALTH
3.	MATERNITY
4/5.	CHILD/MENTAL HANDICAP
6.	MENTAL HEALTH
7.	ADULT
8.	CONSOLIDATION

ADULT CARE BRANCH	
9A	CRITICAL CARE
10A	ACUTE CARE
11A	CONTINUING CARE
12A	CRITICAL CARE
13A	ACUTE CARE
14A	CRITICAL CARE

CHILD CARE BRANCH	
9C	THE HEALTHY CHILD
10C	SICK CHILD (ACUTE)
11C	SICK CHILD (LONG TERM)
12C	SICK CHILD (CRITICAL)
13C	SPECIAL NEEDS
14C	MANAGEMENT OF CARE

MENTAL HEALTH BRANCH	
9M	SKILLS BASED
10M	EXPERIENCE
11M	THROUGHOUT THE
12M	MODULES
13M	(STEINAKER & BELL)

MENTAL HANDICAP BRANCH	
9LD	EDUCATION
10LD	COMMUNITY
11LD	HIGH DEPENDENCY CARE
12LD	BEHAVIOURAL ANALYSIS AND INTERVENTION
13LD	MANAGEMENT OF CARE

4. COMMON FOUNDATION PROGRAMME (C.F.P.)

.1 Aims

To enable students to:-

1.1 acquire an insight into the unique and complex nature of caring.

1.2 acquire relevant knowledge and skills which are common to all aspects of care provision.

1.3 appreciate the existence of and establish links between the different areas of practice.

1.4 acquire a sound base for their ongoing personal and professional development.

.2 Outcomes

On completion of the C.F.P. students should be able to:-

2.1 demonstrate an insight into the unique and complex nature of caring.

2.2 demonstrate knowledge and understanding of the fundamental core subjects, principles, and concepts, that underpin the art and science of nursing care.

2.3 discuss the application of, following periods of observation, and/or apply under supervision, those core knowledge, skills and attitudes to the care of patients and clients of different age, gender, class, disability, race, culture and creed, in a variety of settings.

2.4 demonstrate the acquisition and development of problem solving, communication, observational, caring and assessment skills and the application of these to responsible decision making.

2.5 recognise the potential value and practical implications of research and research based findings in meeting the health care needs of clients: individual, family and society.

2.6 demonstrate evidence of personal and professional growth; e.g., in their ability to operate as self-directed students.

It should be noted that these general aims and outcomes are supplemented by the specific ones of particular modules and units of learning; these are contained in the main submission document and may be made available to you by your Clinical Liaison Tutor.

.3 STRUCTURE

This eighteen months long C.F.P. consists of eight modules, the lengths of which exclude seven weeks of holiday time per year.

The modules are as follows:

Module 1: Health (11 weeks)

This module introduces the theoretical basis of the foundation component of Project 2000. Emphasis is on understanding of the complex nature of health and how this concept applies to the individual family and society.

An introduction to the art and science of nursing includes an examination of the concept of health and the central role the nurse plays in the delivery of health care services.

As a precursor to a module on ill health the healthy individual and family are considered from biological, psychological and sociological aspects. The theoretical input takes the form of formal teaching and group seminars.

During this placement students do not visit clinical areas.

A place in the community enables students to undertake a study to investigate life in a particular area of Centre One.

Module 2: Ill Health (11 weeks)

Having acquired an understanding of health, the ill health component of the Foundation Programme enables an understanding of basic ill health concepts.

Causes of ill health are all considered including a response to:

trauma
infectious disease
disorders of birth

The psychological response to ill health, how individuals cope in this situation, problems with relationships in the family such as instability, violence and the effect of poverty, are all examined.

A nurse's role involves education in the prevention of disease, whether it be in the form of counselling the individual, the family or direct involvement with the critically ill or persons with a long-standing illness. Professional issues in relation to a nurses role and the implication as far as the Health Service and Social Services are concerned are also considered.

Arrangements for academic learning are similar to the Health Module.

However, placements in hospital wards, with a mentor to supervise learning, involves 3½ days each week for the last four weeks of the module. (Three weeks of which in hospital, one week in private health care). One day a week is spent in the College of Nursing in order to develop the theoretical content further.

Module 3: Maternity Module (4 weeks)

The aims of the Maternity Module are threefold:

- to enable students to appreciate pregnancy, childbirth and post-natal recovery as a sequence of normal, healthy, physiological events.
- to give students an opportunity to explore the possible effects of pregnancy and childbirth on the individual, the family and society.
- to enable students to explore the resources available to meet the need of expectant parents and their new-born babies.

This module is divided up as follows:-

Week 1	will be spent covering some theoretical issues relating to pregnancy, childbirth and post-natal period.
Week 2	will be spent gaining clinical experience of hospital based maternity services.
Week 3	will be spent gaining practical experience of community based and alternative maternity services.
Week 4	will be spent exploring some theoretical issues relating to childbirth and its effects on the individual, the family and society.

The maternity component of the Common Foundation Programme will build upon the knowledge and skills which students have gained during previous modules.

Module 4: Child Care (8 weeks)

The purpose of the module is to assist students to develop the relevant knowledge, attitudes and skills necessary to promote optimum health and development for all children.

During this module the child is viewed from three different perspectives.

a) the child as a developing individual
b) the child as a family member
c) the child and family in society

The theoretical component of the module consists of a number of study days which are complemented by a two week period of personal study.

Particular emphasis has been placed on providing a blend of hospital and community based placements to enable students to view the child in health and ill-health. Examples of placements for the module are hospital wards, nursery schools, health clinics/centres, and time spent with Health Visitors.

Module 5: Mental Handicap (4 weeks)

The purpose of the module is to introduce students to the field of Mental Handicap and is principally designed to give students an insight into working with the mentally handicapped individual and their family.

This module includes a period of theoretical and practical hospital and community based placements in which students will encounter a wide variety of learning opportunities.

Throughout this period students will continue to undertake their neighbourhood student activities as in all modules.

Module 6: Mental Health (10 weeks)

Consideration of mental health provides an insight into the nature of health care practices for promoting mental health, and for meeting the needs of individuals with mental ill health.

Nursing in both the community and in the institutional setting has an important role in caring for the needs of individuals with mental ill health and in promotion of mental health strategies.

Professional, legal and ethical implications are crucial in respect of overall care, as is the psychological and sociological response of individuals and their families to mental ill health.

Theoretical learning is interspersed with periods of observational visits to the community and placements in the institutional setting.

Module 7: Adult Care (18 weeks)

The purpose of this module is to give students an opportunity to acquire an insight into issues related to provisions of adult care in health and ill-health.

This module is divided into three components:

i)	Critical Care Nursing	-	6 weeks
ii)	Acute Care Nursing	-	6 weeks
iii)	Continuing Care Nursing	-	6 weeks

Students will complete a week of theory addressing each component, followed by a five week period of educational placements in each setting during which there will be five study days. Examples of the educational/clinical placements for each component are as follows:

i) Critical Care Nursing:
    Accident and Emergency Department
    Intensive Care Unit
    Coronary Care Unit
    Theatre

ii) Acute Care Nursing:
  Medical and Surgical areas
  Theatre

iii) Continuing Care Nursing
  Elderly Care areas
  Young, Chronic Sick Care areas

Module 8: Consolidation of C.F.P. (1 week)

This module is the last one of the C.F.P. following which students will progress to the branch programmes. For its purpose students will be divided into one of three groups in relation to the branch they will undertake, i.e. Child Care, Adult Care or Mental Health.

It will enable students to take stock of the C.F.P. in its totality, acquire an appreciation of the link between the C.F.P. and the branch programmes, and develop a sense of group identity and belongingness prior to undertaking the branch programme.

Through a variety of teaching and learning strategies, e.g. individual and group work, discussions, seminars and case histories, students will be able to demonstrate that they are able to accept nursing as the central focus of the course, with other disciplines contributing to it wherever possible.

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5. BRANCH PROGRAMMES

.1 Introduction

The Branch Programmes (Child Care, Adult Care and Mental Health) will build on the knowledge, skills and attitudes that students have acquired during the C.F.P. As such, they will develop in depth and breadth these attributes whilst making them relevant to the nature of the Branch Programmes, i.e. children's nursing, adult nursing and mental health nursing.

i) Child Care Branch

Students will fulfil the statutory requirement of 20% rostered service which amounts to approximately 31.5 weeks during the Developmental and Consolidation stages.

The structure of this branch programme is as follows:

Developmental Stage (54 weeks exclusive of holidays)

This stage consists of modules:-

The healthy child - 9 weeks

The sick child - 45 weeks divided into:

acute and/or long term illness	15 weeks
acute and/or long term illness	12 weeks
critical care	9 weeks
the child with special needs/handicap	9 weeks

Consolidation Stage (15 weeks exclusive of holidays)

This stage, consisting of one module, will focus solely on the management of care of the child.

ii) Adult Care Branch

The structure of this branch programme is as follows:

Developmental Stage (26 weeks exclusive of holidays)

This stage consists of three modules:

critical care	8 weeks
acute care	9 weeks
continuing care	9 weeks

During this stage students will do a period of internal rotation to night duty of not more than three nights. This will not take place before the first two weeks, nor during the last week of this experience.

Consolidation Stage (42 weeks exclusive of holidays)

This stage consists of three modules:

critical care	14 weeks
acute care	14 weeks
continuing care	14 weeks

During this experience students will fulfil the statutory requirement of 20% rostered service which amounts to approximately 31.5 weeks.

iii) Mental Health Branch

Mental Health nursing is a skill based profession. No specific placements have been identified as in Child and Adult Care branches. Areas which are conducive to enabling students acquire these skills unique to mental health nursing, will be selected and used accordingly during each module of this branch programme.

The structure of this branch programme is as follows:

Developmental Stage (28 weeks exclusive of holidays)

This stage consists of two modules:

9M	14 weeks
10M	12 weeks

Consolidation Stage (42 weeks exclusive of holidays)

This stage consists of three modules:

11M	14 weeks
12M	14 weeks
13M	14 weeks

During this experience students will fulfil the statutory requirement of 20% rostered service which amounts to approximately 31.5 weeks.

Specific details relating to each module of the branch programmes will be available in the near future and may be obtained from your Clinical Liaison Tutor.

6. TYPES OF PLACEMENTS

.1 Common Foundation Programme

Health Module:

Educational institutions, e.g. Colleges
Occupational Health Departments:
    Industries and Commerce
Self Help Groups e.g. Weight Watchers
    Well men/women
Shops, e.g. Mothercare
Recreation/Leisure Centres
Restaurants/Pubs
Cultural/Racial Groups

Ill Health Module:

Hospital Wards: Medical, Surgical, Rheumatology, etc.
Private Health Sector: Residential Homes, Private Hospitals

Maternity Module: for example-

Hospital Wards
Parentcraft Class
Antenatal/Postnatal Clinic

Child Care Module:

Hospital Wards
Out-patient Departments
Day Units
L.E.A. Schools, Play Groups, Mother and Toddler Groups,
    Nursery Schools, Crèches, Day or Residential Nurseries
Health Clinics/Centres, assessment units.
Health Visitors and School Nurses

Mental Handicap Module

Schools for Mental Handicap
Social Services
Youth Clubs and Play Schemes
Voluntary Sector: Mencap
Pre-school service
Nursery Schools: Social Services and L.E.A.
Voluntary Forum
Face and Stop Scheme: Substitute Family Schemes,
    Befriending

Mental Health Module

Hospital Wards, Rehabilitation Departments and Day Units
Community Placements with Community Psychiatric Nurses
Support Scheme
The Shop Front
Association for Mental Health
Day Centre for Homeless
Schizophrenia Fellowship

Adult Care Module:

Critical Care areas: Accident and Emergency Departments, Coronary Care and Intensive Care Units and Perioperative areas

Acute Care areas: acute medical and surgical areas, theatre departments

Continuing Care areas: continuing care wards/units for the elderly and young chronic sick.
Hospice (for visits)

.2 Branch Programmes

Child Care: Critical, Acute and Continuing Care areas and special needs/ handicap placements.

Adult Care: repeat of areas identified in section 7 of Common Foundation Programme

Mental Health: repeat of areas identified in section 6 of Common Foundation Programme and others as appropriate.

APPENDIX 2

Centre 2 Course Outline

DIPLOMA IN HIGHER EDUCATION (NURSING STUDIES)

GENERAL COURSE STRUCTURE AND ORGANISATION SHOWING ANNUAL LEAVE

YEAR 1

COMMON FOUNDATION PROGRAMME

← ← ← ← ← ← ← PART ONE → → → → → → →						← ← ← ← PART TWO → → → →		
1 - 8	9 - 17	18 - 20	21 - 26	27 - 26	37	38 - 39	40	52
Introduction to Course	← UNIT 1 → Environmental Health Studies	Annual Leave	← Prep	← UNIT 2 →	EVAL	Annual Leave	← Prep	← UNIT 3 →

YEAR 2

← ← ← ← ← PART TWO (cont.) → → → → →						← ← ← ← PART THREE → → → →			
53 - 55	56	59 - 61	62 - 73	74 - 75	76 - 78	79 - 82	83 - 99	100	101 - 104
	EVAL	Prep	← UNIT 4 →	EVAL	A/L	Prep	← UNIT 5 → Experience	EVAL	A/L

YEAR 3

← ← ← ← ← ← ← ← ← ← ← ← PART FOUR → → → → → → → → → → → →						
105 - 109	110 - 126	127	128 - 131	132 - 136	137 - 155	156
Prep	← UNIT 6 → Experience	EVAL	A/L	Prep	← UNIT 7 → Experience	A/L

A/L - Annual Leave
Prep - Preparation study phase
Eval - Evaluation of Unit Learning/Assessment
Experience - Clinical Experience

PROJECT 2000 COURSE HOURS

Theory in Hours - Common Foundation Programme =	1,428	hours
Theory in Hours - Branches =	959	hours
Total Theory =	2,387	

Allowing 20%	Input 2387 x 20%		
(Common Foundation Programme 60%		= 285 hours)	
(Branches 40%		= 190 hours)	= 477 hours

Theme Unit	Individual in Society	Health	Systematic Care	Management	Research	Professional Development	Total
1	Stress Management 3.5 (B.P.) Sociology 21 Psychology 21 Immunology 7 Biology 10 Biochemistry 10 Microbiology 7		Problem Solving 7 (B.P.)	14 (B.P)	IT 7 Research Method 7	Learning Styles 3.5 (T.S)	17 Days 119 Hours
2	Communications 7 (B.P.) Sociology 21 Psychology 28 Immunology 7 Biology 14 Biochemistry 7 Microbiology 7			28 (B.P.)	IT 7 Research Method 7		20 Days 140 Hours
3	Sociology 14 Psychology 21 Biochemistry 3.5 Microbiology 3.5 Immunology 3.5		Int. 7 (B.P.)	28 (B.P.)	IT 7 Research Method 7 Data Gath 3.5 (B.P.)	Teacher 10.5 (T.S.)	15 Days 105 Hours
4	Sociology 3.5 Psychology 3.5			Budget 7 Skills 14 (B.P.)	IT 7 Research Method 7		6 Days 42 Hours
5	Sociology 3.5 Psychology 3.5			Skills 14 (B.P.)	IT 7 Research Method 7	Teaching Teachers 7.5 (T.S.)	6 Days [illegible] Hours
6	Sociology 7.0 Psychology 7.0			Skills 14 (B.P.)	IT 7		5 Days 35 Hours

Total = 69 Days; 483 Hours

CENTRE TWO - COURSE STRUCTURE & PROGRAMME

<-----------------------------------PART ONE--------------------------------------->

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
INDIVIDUAL IN SOCIETY																	A/L		

<-------------------------------------PART TWO-------------------------------->

21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39
SPECIAL NEEDS OF THE INDIVIDUAL																	A/L	

<-------------------------------------PART TWO(cont)---------------------------->

40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58
SPECIAL NEEDS OF THE INDIVIDUAL																	A/L	

<-------------------------------------PART TWO(cont)---------------------------->

59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78
SYSTEMATIC CARE																	A/L		

<--------------------------------------BRANCH PROGAMME (PART THREE)--------------------------------->

79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104
ADULT - CARE OF INDIVIDUAL WITH MEDICAL HEALTH PROBLEMS MENTAL HANDICAP - CARE OF INDIVIDUALS WITH SPECIAL THERAPEUTIC NEEDS MENTAL HEALTH - CARE OF INDIVIDUALS WITH LONG STANDING MENTAL HEALTH PROBLEMS																						A/L			

<--------------------------------------BRANCH PROGAMME (PART FOUR)------------------------------------->

105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131
ADULT - CARE OF INDIVIDUALS IN FAMILIES (SURGICAL / TRAUMA) MENTAL HANDICAP - CARE OF INDIVIDUALS AND FAMILIES MENTAL HEALTH - CARE OF ELDELY WITH MENTAL HEALTH PROBLEMS																							A/L			

<---------------------------------BRANCH PROGAMME (PART FOUR - cont)------------------------------------>

132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158
ADULT - CARE OF INDIVIDUALS & GROUPS (MEDICAL / SURGERY) MENTAL HANDICAP - CARE OF INDIVIDUAL, FAMILY & GROUPS MENTAL HEALTH - CARE OF INDIVIDUAL & GROUPS WITH ACUTE MENTAL HEALTH PROBLEMS																								A/L		

RANGE OF PRACTICAL EXPERIENCES
COMMON FOUNDATION AND BRANCH PROGRAMMES

COMMON FOUNDATION

UNIT 1	UNIT 2a	UNIT 2b	UNIT 3
Environmental Health Officers Primary Health Care Teams Occupational Settings Leisure/Recreational Settings Schools Parent Craft Classes Crèches/Playgroups	Schools for the Individual with Learning Difficulties Community Mental Health placements Adult Nursing placements Nursing the Sick Child Maternity Care - Antenatal Care - Care of the New-born Primary Health Care Team		Negotiated placement in Tertiary Health Care areas reflected in:- Adult Nursing - Hospital Mental Handicap Nursing - Community Mental Health Nursing - Community - Hospital

BRANCH PROGRAMMES

UNIT 4	UNIT 5	UNIT 6
MENTAL HANDICAP BRANCH Residential Units for Adults Families Specialist therapeutic area:- - speech therapy - sensory handicap unit - art therapy - recreational therapy	Residential Unit for Children Families Schools for Children with Learning Difficulties	Residential Units for Adults Residential Units for Elderly Community Mental Handicap Team Families
MENTAL HEALTH BRANCH Community Psychiatric Teams (Rehabilitation) Rehabilitation Training Unit Hostels (Health and Social Services)	Community Psychiatry Teams (Elderly) Assessment and Respite Care Wards Day Hospital for the Elderly	Community Psychiatry Team (Acute Services) Day Hospital (Acute Services) Acute Psychiatric Wards 4 Special Care Units:- - Acutely Disturbed Behaviour - Alcohol and Drug Dependency
ADULT NURSING BRANCH Acute Services Medical Units:- - Acute Medical Wards Community Nursing Specialist therapeutic areas:- e.g. - Radiology Units/Departments - Endoscopy Units	Acute Services Surgical and Trauma Units:- - Surgical Wards - Orthopaedic Wards Accident and Emergency Department - Operating Department	Acute Services:- - Medical Units - Surgical Units Special Units:- - Intensive Care Units - Coronary Care Units

COMMON FOUNDATION AND BRANCH PROGRAMMES

	COMMON FOUNDATION PROGRAMME			BRANCH PROGRAMME		
	PART 1	PART 2		PART 3	PART 4	
	HOLISM **Environmental factors influencing health**	**Interpersonal, Teaching, Stress and time management skills**	**Synthesis of previous knowledge** **Assessment and Planning Basic Psychomotor,, skills and attitudes.** **Further development of nursing skills using a rehabilitative approach.**	**ADULT** **- Rehabilitation skills** **MENTAL HEALTH** **MENTAL HANDICAP - Therapeutic skills**	**Application of Health Promotion skills and Health Care Problems Solving Skills - individual and his family**	**Application skill** **- Assessment** **- Planning,** **- Implementation** **- Evaluation** **Health Promotion and Safety** **Discharge Planning** **Team Management/ Resource Management**
COURSE THEMES THE INDIVIDUAL IN SOCIETY	Self Awareness Communications Bio-Psychosocial sciences Environment Learning Skills	Bio-Psychosocial theories to health and nursing. Effects of Hospitalisation Stress management	Effects of illness/ disability on the individual. Individuality in care.	Effects of physical illness, mental illness or mental handicap on the individual	Effect of physical and mental illness or mental handicap on the individual and his family.	The integration of Bio-Psychosocial theories to the practice of nursing and the application of therapeutic techniques.
PROMOTION OF HEALTH	Own Health Environmental influences Health assessment Health concepts Epidemiology	Models of health promotion Assessment of health needs Health education relating to special client groups Services available for preventive care	Primary, Secondary and Tertiary Health Health teaching Epidemiological trends Factors influencing uptake of health education	Informed choice on health care Planning/teaching health promotion Risk taking	Identifying urgent health needs Partnerships in health promotion Promoting compliance in health care	In all settings - Identifies health needs employs strategies to meet these needs

SYSTEMATIC CARE	Concepts of care giving Explore problems solving approach	Development of assessment skills Communication skills in nurse/client relationship	Application of the whole process of systematic care in a rehabilitative framework Working in a multi-disciplinary team	Long-term goal settings Alternative approaches to care Mental Handicap - life planning	Partnership in care Holistic care of the patient/client and his family Innovations in care	In all settings - Utilises problem solving approaches to care
MANAGEMENT IN NURSING	Health care systems/ organisations Managing self Principles of Management	Economics and political influences on the implementation of health care Quality assurances and standards Leadership styles and principles Time management Group dynamics	Organising care of individuals Team work Managing change Decision making	Application of organisational principles Self as a Leader Strategies for change Resource management	The nurse as a change agent Crisis management Monitoring care resources Identification of additional resource	In all settings - Manages - self appropriately groups of patients/clients and necessary resources
NURSING RESEARCH	Explore relevances of nursing research to practice Research process Ethnographic research Information Technology Computer skills	Examine specific nursing research and apply to practice Information systems Computer record systems Further aspects of ethnographic research	Application of the use of a research tool Applying research data to care Using Information Technology in Care	Appraise and Application of specific research based data to clients of specific branches Qualitative and quantitative data	Appraise and apply relevant research to the care of the patent/client and his family using qualitative and quantitative data	In all settings - Integrates nursing research into care delivery
PROFESSIONAL DEVELOPMENT IN NURSING	Learning styles Concepts of professionalism Explore health and social issues	The ethics of nursing and ethical dilemmas Legal aspects of nursing Belief systems Primary Care	Accountability Specific ethical dilemmas Parameters of responsibility The nurse as a teacher	Promote equalities in health care Advocacy Helping junior colleagues	Resolution of ethical conflicts Utilising resources Acting as an advocate Assuming responsibility and accountability	Identifies own professional career path Evaluates personal effectiveness and performance

UNIQUENESS OF THE BRANCHES

UNIQUENESS OF THE BRANCHES	ADULT NURSING	MENTAL HANDICAP NURSING	MENTAL HEALTH NURSING
PHILOSOPHY	Health-illness continuum - focus towards ill-health. Health promotion	Social, education and training aspects of care, social role valorisation, emphasis on community and multiprofessional based care. Prevention of mental handicap.	Rehabilitation, promotion of mental health and prevention of mental ill-health. Shift from institutional to community care.
CLIENT GROUP	Individuals and groups experiencing physical illness and or health needs and their families.	Individuals and groups who have a mental handicap and their families.	Individuals and groups who are experiencing mental ill-health and those who have the potential within their social and political setting.
* KNOWLEDGE BASE	Causation, nature and effects of physical illness within their social and political setting. Interrelationship to conceptual models of nursing. Rehabilitation and adaptation. Nursing skills relevant to care of clients with specific physical illness eg trauma, acute and chronic illnesses. Specific legislation, policies and ethical issues. Supportive agencies and services.	Causation, nature and effects of mental handicap/learning disabilities on individual, family and community. Process of learning and development. Education and training for development. Habilitation and rehabilitation. Use of self as a therapeutic agent. Specialised techniques eg communication, behaviour, therapy, drama, touch therapy, occupational and art therapies. Shared action planning, life planning. Specific legislation policies and ethical issues. Supportive agencies and services.	Nature and effects of mental illness. Prevention of mental ill-health. Resettlement, restoration, models of nursing. Use of self as a therapeutic agent. Studies in specialised techniques eg music therapy, psychodrama, recreational, and social therapies, communication. Specific legislation policies and ethical issues. Supportive agencies and services.
PRACTICAL PLACEMENTS	Medical wards, surgical wards, Accident and Emergency, Theatres, trauma wards, community nursing teams.	Residential establishments - Health Service, Social Services and voluntary Agencies, clients homes, Therapeutic units and departments eg sensory handicap and communication, art therapy. Special Education schools, Community mental handicap teams.	Rehabilitation training unit, Hostels, day hospitals, Community Psychiatric Nursing Teams, Community Psychiatric Nursing Rehabilitation Teams. Respite care units, 'In-patient' units.

* Topics that have a common core have not been identified here.

The ways in which the level of the course progress from the Common Foundation Programme to the Branches

The way in which the level of the course programmes from the Common Foundation Programme to the Branches is influenced by seven main features that are built into the curriculum design as follows: the unit and course objectives, the practical placements and their inter-relationship with the theoretical component, a similar to complex approach, the six core themes, a study of health and rehabilitation. All of these are interrelated in the overall curriculum. The two main aspects are outlined below.

EXPOSITION OF COURSE AIMS AND OBJECTIVES

Taxonomy Employed	Rational	Approach	Inter-relationship of Theory and Practice	Relationship to Assessment of Theory	Relationship to Assessment of Practice
Mainly Bloom, B.S (1956)	Guide teaching and learning. Identify standard of critical/essential content. Enabling presentation at various levels of complexity both theory and practice based	Simple to complex approach to theory and/or practice. Both become more complex as the course progresses. (see overview of unit placement below)	Bondy's continuous assessment outcomes adapted to match theory objectives	Criteria designed on Bloom's Taxonomy	Specification grid adapted to inter-relate with theory criteria
Unit One "The Individual in Society" Community Based	To base the course on health promotion and education. Develop a proactive attitude in the student. Evaluate the influence of the environment on the individual's health	Exploration of local community and its impact on health	Study of the environment and its relationship to health. Examination of own health and attitudes	Environmental study. Essay based on unit objectives.	Observations. Skills re-physical, psychological, social and spiritual domain. Communication, record keeping. Self time management.
Unit Two "Special Health Needs of the Individual"	To evaluate the effects of special environments on the individual. Develop assessment, planning psychomotor, stress and time management skills. Gain broad view of the nursing specialities	Community mental health placements. Mental Handicap placements. Adult nursing. Primary health care teams and maternity care.	Studies and participates in assessment planning, implementation and evaluation of a care programme. Studies and participates in the implementation of a health teaching plan	Client centred health profile. Micro-teaching package. Client centred care study. Examination based on unit objectives	Assessment on basic planning., implementation and evaluation skills. Data collecting, health profile, team skills
Unit Three "Systematic Care of Individuals"	Further development of knowledge, skills and attitude of previous unit. Integration and synthesis of knowledge, skills and attitudes re-systematic care for individuals and families. To introduce the concept of rehabilitation	Practical placement will be negotiated. Tertiary health care settings	Studies and participates in the assessment, planning, implementation and evaluation of a nursing care programme for a client and family. Studies and participates in rehabilitation techniques.	Client centred nursing care study. Emphasis on planning and implementation. Written examination based on unit objectives.	Assessments focuses on planning and implementation of care. Application of research data. Data collecting and self management and team work.

Unit Four					
1) "Care of the adult with medical health problems"	Further development of unit three. Develop knowledge, skills and attitudes of nursing a client who is experiencing medical health problems. Physical disability. Further development of rehabilitation concepts.	Medical wards, rehabilitation units, primary health care teams, social services	Studies and participates in the assessment, planning, implementation and evaluation of nursing care of clients with medical health problems, physical disability	Nursing study, focus sources of knowledge and its relationship to client care. Case study. Written examination based on unit objectives	Assessment focus on assessment, planning, implementation and evaluation of client care programmes, includes rehabilitation, health promotion and application of research data
2) "Care of the individual with special needs"	Enable student to develop knowledge skills and attitudes re-implementing therapeutic programmes and rehabilitation	Range of residential and therapeutic settings	Studies and participates in therapeutic, rehabilitation, social therapy, programmes	As above	As above
3) "Care of the individual with long standing mental health problems"	Develop knowledge skills and attitudes re-long standing mental illness, nursing practice. Further aspects of rehabilitation, resocialisation and social therapies	Community psychiatric team rehabilitation training unit and hostels	Studies and participates in rehabilitation, social therapies and resocialisation programmes	As above	As above
Unit Five					
1) "Care of adults and their families experiencing surgical interventions and traumatic injury"	Consolidation and further development of knowledge, skills and attitudes in unit four. Develop further knowledge of family, primary carers, teaching. Knowledge and skills re-surgical and traumatic injury.	Surgical wards, operating theatre, accident and emergency and trauma wards	Studies and participates in the assessment, planning, implementation and evaluation of nursing care programmes for clients and their families in the student's specialist area. Family dynamic, partnerships with families	Selects an aspect of caring for an individual and their family, emphasis role of teaching and education, select and critically evaluate on aspect of a nursing care plan in the light of a professional nursing issue	Assessment, focus on assessment, planning, implementation of client care programmes and their families, application of research data, health education, and management concepts
2) "Care of the individual and their families"	Develop further therapeutic skills. Working is partnership with the family. Further aspects of educational system	Children and adult residential units. Schools. Families	As above	As above	As above
3) "Care of the elderly individual with mental health problems and their families"	Develop knowledge, skills and attitudes essential to the care of the elderly individual, family, primary carer	Community psychiatric nursing team. Assessment unit and respite care, day hospital	As above - emphasis on the elderly	As above	As above

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Unit Six 1) "Care of individuals and groups experiencing medical/surgical conditions	Consolidate and develop further knowledge, skills and attitudes from previous units incorporation, families, groups, ward unit management, service provision, innovation. Preparation for the role of Registered Nurses	Negotiated	Studies and participates in the assessment, planning implementation and evaluation of care programmes for individuals and groups. Management of a group of clients	Critical examination of a professional / clinical nursing a mangement issue. Emphasis on evaluation, resources and innovation.	Comprehensive assessment of the management of individuals and a group
2) "Care of individuals and families, groups"	As described on page 10	Residential placement, families, community mental handicap team	As described on page 10h, specific to clients with a mental handicap	As described on page 10h, specific to clients with a mental handicap	As described on page 10h, specific to clients with a mental handicap
3) "Care of the individuals and groups with acute and special mental health problems	As described on page 10h, specific to clients with a mental handicap	Community psychiatric nursing team, day hospital, psychiatric in-patient services (acute)	As described on page 10h, specific to clients with a mental handicap	As described on page 10h, specific to clients with a mental handicap	As described on page 10h, specific to clients with a mental handicap

1) = Adult Nursing
2) = Mental Handicap Nursing
3) = Mental Health Nursing

APPENDIX 3

Biographies of Research Team

Jill Macleod Clark, PhD BSc RGN

Jill Macleod Clark is Professor of Nursing and Director of the Nightingale Institute at King's College London. The Nightingale Institute has over 900 students registered on the Project 2000 programme. She trained as a nurse on a "traditional" nurse training programme at University College Hospital and subsequently worked in a variety of posts in hospital and the community. She has been involved in academic nursing as a teacher and researcher since 1979. Her extensive research activities focus on communication skills and health promotion, particularly smoking cessation. She has published widely and is committed to developing the nurse's role as a promoter of health.

Jill Maben, MSc BA (Hons) RGN

I trained as a nurse at Addenbrookes Hospital, Cambridge 1972 - 1982. I commenced the training aged 18, having come straight from school. The pre-registration course was for the most part a "training" to enable me to perform tasks on the ward. There was no input on health promotion, interpersonal skills or sociology and psychology, the course being based on the medical model. Once qualified, I worked on a female medical ward in Cambridge before moving to a male medical and dermatology ward in London. My training equipped me to perform the tasks required of a nurse, but not to "nurse". I did not nurse holistically, reflect on my practise and was totally unaware of research. I had not been educated to think and the strict nursing and hospital hierarchy ensured that I never questioned my own or others practices.

I felt particularly unsupported as a newly qualified nurse and by 1984 was no longer enjoying nursing. I therefore left the profession and commenced a degree in History full time for three years. This period allowed me to reflect on my nursing career and I was drawn back into the profession. I worked as a staff nurse on a continuing care of the elderly ward upon completion of my degree, 1987-88. The long-term nature of the clients on this ward allowed me to practice more holistically and to have time to develop relationships. My enjoyment and satisfaction in nursing increased further with a year's contract on a gynaecology/oncology ward in Melbourne, Australia. where I became interested in patient education and health promotion. On returning to the UK I commenced working in nursing research at Kings College, London. Prior to this study I was engaged in a national project examining nurses perceptions of health education and health promotion. This study inevitably increased my own knowledge of the concepts which are central to my own philosophy of nursing. I perceive an understanding of the social and economic determinants of health as central to effective nursing care and feel the role of politics can not be ignored.

Karen Jones, BA (Hons) RGN HV Dip

I commenced my general nurse training in 1980 in a hospital in Kent (The William Harvey). The course followed a traditional programme and seemed to me to instil the virtues of patient focused care whilst working within and beneath the hierarchical structure of the environment in which you found yourself.

Upon qualification, I worked on an acute surgical ward (night duty) and soon found myself immersed in the "reality shock" of qualified practise. I survived for six months before leaving for a job in Cambridge at the Addenbrookes Hospital working in plastic surgery. This was a completely new field for me but one I found utterly absorbing in two ways. The need for precision and ingenuity kept may attention whilst the obvious unmet psychological need maintained my frustration. This frustration lead to my application to Sussex University to undertake a degree in Social Psychology. This course explored how people function within groups, the dynamics and issues. I became increasingly interested in the more "social aspects" of health care and provision. This interest was expanded upon during my Health Visitor Diploma which followed immediately upon graduation.

The Health Visitor course heightened my belief in the need to begin first from the client's perspective, whenever attempting to define any health need. I also developed a strong commitment to community based initiatives, acknowledging the fundamental influence which social policy and politics in general play on the lives of people who create communities.

Having reflected upon this amalgamation of my professional career, it becomes apparent that my philosophy of nursing and that of health care in general is indeed based upon the concepts and experience of:

* Working within and against hierarchical structures.
* The impact and challenge of an immediate transition from protected to complete responsibility.
* An appreciation of the psychological factors which influence and determine response to and recovery from "dis-ease".
* The essential need to begin not from the professional's interpretation but that of the client, who is experiencing the situation from their own unique perspective.
* And finally, the overwhelming recognition that health is both determined and manipulated by the impact of political governing.

APPENDIX 4

Personal Letter to Individual Members of the Institution

A Detailed Study of Project 2000: Perceptions of the Philosophy and Practice of Nursing.

A three year study commissioned by the English National Board

March 1993

Dear Colleague

X College has been selected as a case study centre for the above study, and I am writing in my capacity as Research Associate to introduce this important project to you.

As you will see from the attached summary document we hope to explore the perceptions of students, practitioners, managers and teachers regarding the philosophy and practice of nursing as influenced by the implementation of Project 2000. I realise that as a demonstration district you will be well used to being 'researched', and I hope that you will feel able to assist, if necessary, with yet another project!

We aim to collect data from students via questionnaires. Data collection for this part of the study will be spread over eighteen months, and we hope to be able to access students at nine monthly intervals, three times in this period.

We also plan to give questionnaires to some students who will complete the course, in the life of this project. We aim to access them during their first six months after qualifying, and a small sample will be invited for interview.

Qualified practitioners and nurse managers working with Project 2000 qualifiers will be interviewed and teachers such as yourselves will also be asked to consent to taking part in an informal group interview with a member of the research team. This will however be towards the end of the data collection period (i.e.1994) and I will of course contact you nearer the time with more information.

I recognise that these are busy and difficult times for many of you, but hope you will feel able to support this research. If you have any questions please do not hesitate to contact me at the above address, or on 071-872 3210 (tel. no)

Best wishes

Yours faithfully

(Name)
Research Associate

APPENDIX 5

Project Summary Document

Three year project commissioned by the English National Board

Project 2000: Perceptions of the Philosophy and Practice of Nusing

Summary Document

Professor Jill Macleod Clark

Karen Jones (Research Associate)

Jill Maben (Research Associate)

Focus of study

> *"Projects 2000's educational approach reflects an intention to influence the status of nurse education through the reframing of nursing curricula and the reorganization of nursing knowledge. The Project 2000 curriculum must be a theory and practice programme embedded in health not illness, providing the student with experience of a range of settings and a variety of care groups."*
> *(UKCC 1986)*

The main theme of enquiry is in understanding the contribution that nurse education today, will make on the perceptions of the philosophy and the practice of nursing and on the process of the socialization of the students into their professional role in the future. The focus of study is therefore to examine the 're-organization' of nursing knowledge and the 're-framing' of the nursing curriculum, to assess its impact upon the process of occupational socialization for the new Project 2000 practitioner. We shall explore the existence and effect of a shared knowledge base underpinning all branch programmes, and its wider influence on the shared values and beliefs within nursing.

Method:

A multi-case study approach will be utilized using two sites within Britain. The unit of analysis will be the perceptions of the students, practitioners, clinical managers, and teachers regarding the philosophy and practice of nursing as influenced by the colleges implementation of Project 2000. In order to assess the various interactive processes, the study will use 'a multi-method' approach to data collection. Questionnaires and interviews are to be the dominant form of data collection, the former to identify broad spectrum views, the latter to focus on identified issues. Focus group interviews will also be utilised when exploring the perceptions of both nurse teachers practitioners and clinical managers.

Data Collection:

Pilot Study - (Undertaken in a non-case study centre)

Questionnaire Piloting:

- Project 2000 students from both common foundation and branch programmes, and qualifiers (n = 50).

Focus Group Interview

- Nurse teachers of Project 2000 students
- Clinical Managers of G grade practitioners
-practitioners within the clinical environment, working with Project 2000 students and qualifiers

Case Study Sites

Contextual Data Collection

- Gained by attending meetings, reading relevant course literature, reports and documentation

Questionnaires

- Designed from pilot study and a review of the literature, administered to Project 2000 students and qualifiers.

Semi-structured interviews

- Based upon questionnaires previously completed to form an loose interview schedule with Project 2000 qualifiers.

Focus Group Interview

- Teachers of Project 2000 students
- Clinical managers of G grades
- Practitioners working with Project 2000 qualifiers

Consent and Confidentiality

Informed consent will be obtained from all those participating in the study and participants will be free to terminate involvement at any stage. Questionnaires and interviews will be coded to ensure anonymity and confidentiality. All data held on computer will be accessible to the research team only, and coded for further protection.

Sample

Students

The main aim is to examine how the students' perceptions of nursing may have changed during the course and explore their perceptions of the future professional contribution to be made within a wider context of 'multi-disciplinary' care provision.

Students will be accessed via the college and invited to participate on a voluntary basis. Sampling would need to reflect branch size to achieve a balanced sample across all branches offered by the centre.

In each case study centre participating students will be given an initial entry self completion questionnaire (n = approx 250 per case study centre) focusing upon their perceptions of the nature of nursing to provide baseline data reflecting their socialization and expectations. Students from four cohorts in each study centre will be invited to participate, and will be followed up at nine monthly intervals to give a set of three questionnaires per individual. Subsequent to completion, a smaller sample of 'qualifiers' will be invited for interview (n=10 per case study centre). The questionnaire will be utilized as an informal interview schedule, thus sharing with the student the research tool and enriching for the researcher the findings from the questionnaire. Interviews will be tape recorded with the students permission to ensure accurate qualitative analysis.

Practitioners

A small sample of clinical practitioners will be identified. Selection will be determined by involvement with Project 2000 students qualifiers and accessed via clinical management.

Data will be collected via focus group interviews which are designed to elicit their perceptions of the qualified Project 2000 qualified nurse as a professional practitioner, and as a promoter of health. The interview will enable qualitative exploration of themes pertinent to the perceived differences (if any) between Project 2000 nurses and traditionally trained nurses.

Teachers

A sample of teachers will be identified according to contact and involvement with Project 2000 students, with a distribution reflecting branch programme involvement.
Consenting teachers who have been involved in the Project 2000 course since inception, if possible will be invited to participate in a focus group interview. The sample will aim to reflect the breadth of subjects and branch programmes offered by the college. The focus would be upon their views on 'changes' within the curriculum and on emerging issues and problems in terms of professional socialization.

Clinical managers

A sample of people who manage G grade clinical nurses will be identified and invited to participate in an informal focus group interview. The sample will aim to reflect both hospital and community managers, and managers in areas reflecting all branch programmes. The focus group interview would plan to explore managers perceptions of the 'effectiveness' of these new practitioners in practice

Conclusion

From the data a variety of factors affecting the philosophy and practice of nursing will emerge, namely, students and qualified diplomates' perceptions of nursing, and teachers opinions of curriculum changes and their views on the changing focus of nursing and nurse education. Practitioner and clinical manager's views will also be clarified concerning their understanding of how the Project 2000 qualifier appears in practice.Their views would balance the exploration of 'change' by their focus upon practice and the influence of these 'new practitioners' upon nursing in general, thus enabling points for consideration regarding the continuing development of nurse education and training to be identified.

APPENDIX 6

Letter To Service Personnel

Name
Address

Date

Dear (name)

I am writing to you in my capacity as a research associate from King's College University of London, where I am currently working on a project commissioned by the English National Board examining 'The Perceptions of the Philosophy and Practice of Nursing within the context of Project 2000'.

Your area has been selected as one of the study sites for this project, and I am therefore writing to introduce this important project to you. I enclose for your information a copy of the research summary document. To date the project has been concentrating on the education side and I have been liaising with X in the Faculty of Health Care.

I am now seeking your assistance in organizing and negotiating access to students in the clinical areas and practitioners who work with qualified Project 2000 nurses together with those who are responsible for managing the practitioners. As you will see from the enclosed documentation we are hoping to interview RGN practitioners (F/G grades) who work with qualified Project 2000 nurses, and the qualified Project 2000 practitioners themselves. We are also keen to get the views of personnel who manage the F & G grade practitioners, and plan to try and set up a focus group interview for this purpose. I would appreciate your help in organizing access to these groups.

The project may require clearance by a nurse research and ethics committee, and I would appreciate any guidance you may be able to offer in this area. I anticipate data collection commencing in May / June 1994, and are therefore anxious to negotiate any ethical clearance that may be necessary as soon as possible.

I do appreciate that these are hectic times for nurse managers and clinical staff alike, I would therefore be grateful for your support in making this project as unobtrusive as possible.

I look forward to hearing from you and would welcome your advice on how best to proceed. If you have any queries please do not hesitate to contact me on the telephone numbers below.

Best wishes
Your sincerely

(Name)
Research Associate

APPENDIX 7

Student Questionnaire Pre-Pilot Work

Pre-pilot work was undertaken from January 1993 - April 1993. Each pre-pilot study was re-testing any amendments made and / or was testing the tool on students on different branch programmes, or at different stages on the course.

Pre-pilot studies were undertaken with students in three different Nurse Education Institutions, one in the south of England and two in the north of England. In total 68 students completed questionnaires in the pre-pilot centres. Table x below outlines the stages on the course of these students and their branch programmes:

Table 49: Pre-pilot study sample

	4 months	6 months	9 months	24 months	30 months	36 months	TOTAL
CFP	n = 10	n = 24	n = 6				n = 40
Adult branch				n = 7	n = 8	n =6	n = 21
Child branch						n = 3	n = 3
M/Health branch						n = 4	n = 4
TOTAL	n = 10	n = 24	n = 6	n = 7	n = 8	n = 13	n = 68

APPENDIX 8

Questionnaires A - E

I.D. CODE: ☐ ☐ ☐ ☐ ☐ ☐
(For Researchers Use)

Three Year Project Funded by the English National Board.

Project 2000 Study

Questionnaire for Students

All information is strictly confidential and will be coded for anonymity

Section One:Background Details.

Everything is entirely CONFIDENTIAL, and you will not be identified. This information will ONLY be used for the purposes of the project, and will not be available to anyone outside the project team.

Questions asked in Questionnaires

[001] Age......................Years **ABD**

[002] Male ☐ Female ☐ **ABD**

[003] Date of commencing course..................................... **ABD**

[004] Do you know which branch programme you will be studying? **ABD**

Yes ☐ No ☐

If 'Yes', please indicate which one, by ticking the appropriate box:

☐ Adult

☐ Mental Health

☐ Mental Handicap/
Learning Disabilities

☐ Child

[005] Academic / Professional Qualifications (e.g. GCSE's, OND/HND, Enrolled Nurse etc.) **ABD**

....
....
....
....
....

[006] Previous work experience (and approximate length of time at each): **ABD**

....
....
....
....
....

The aim of this research is to begin to clarify the effect of the Project 2000 on the "new nurse of the future", which will of course be yourself.

The following questions attempt to firstly explore 'your' experiences within the Project 2000 course and secondly, your views and understanding of nursing. Please answer ALL questions in as much detail as you can.

Some questions will ask you to make a choice, and will ask you to tick the box which corresponds best to your answer.

FOR EXAMPLE:

YES ☑ **NO** ☐

Other questions will ask you to RATE your response, by circling the number that best corresponds to your answer.

FOR EXAMPLE:

extremely easy			**not at all easy**
4	3	[✓ 2]	1

Section Two - Early views and expectations of nursing.

Please answer all the following questions and try to recall how you felt as you first began your Project 2000 course.

[007] Did you specifically want to do a Project 2000 course? **ABD**

YES ☐ NO ☐

[008] Why have you undertaken your training in this centre? **ABD**

[009] What did you think nursing was about before you began your Project 2000 course? **ABD**

[010] When you applied what did you hope to get out of nursing? **ABD**

[011] What are your future career plans? **ABCDE**

Section Three -Practical experience relating to your educational experience.

[013] How easy, in general do you find it to relate what you have learnt in college to the practical situation within your placements ? **CDE**

extremely easy			not at all easy
4	3	2	1

Comments:

[012] During your course, do you think it will in general, be easy to introduce' ideas obtained from the college into the practice area ? **AB**

extremely easy			not at all easy
4	3	2	1

Comments:

[015] How easy, in general, do you find it to relate what you have learnt in your practice areas to your work in college? **CDE**

extremely easy			not at all easy
4	3	2	1

Comments:

[014] During your course, do you think it will in general, be easy to 'introduce' ideas obtained from the practice area into the college ? **AB**

extremely easy			not at all easy
4	3	2	1

[016] What do you understand by the term 'nursing care' ? **ABCDE**

[017] What do you think is required for 'good' nursing care ? **ABCDE**
Please state your answer in order of importance, with 1 being the most important:

[018] Would you in general make a distinction between the terms health education' and 'health promotion'? **ABCDE**

YES ☐ Please state what you understand by each term:

Health Education:

Health Promotion:

NO ☐ Please state what health education/health promotion means to you:

[019] In your opinion, how difficult is it to put health education / health promotion into practice in the clinical environment? **CDE**

Extremely difficult — Not at all difficult

4 3 2 1

If you have circled 3 or 4 please describe any difficulties you have encountered:

If you have circled 1 or 2 please describe what facilitates this:

[020] It has been suggested that Project 2000 nurses will find it more difficult to practice than traditionally trained nurses, because the course is based on theory rather than on practical skills. To what extent do you agree with this view ? **BCDE**

Strongly disagree — Strongly agree

4 3 2 1

Comments:

[021] To what extent do you agree with the statement: **BCDE**
" there is a distinction between the 'real' world of nursing and the ideal' world of nurse education".

Strongly agree — strongly disagree

1 2 3 4

Comments:

[022] What five qualities do you think a "good" nursing student possesses ? **ABCDE**

Please state your answer in order of importance, with 1 being the most important.

1.
2.
3.
4.
5.

[023] What five qualities do you think a "good" tutor possesses ? **ABCDE**

Please state your answer in order of importance, with 1 being the most important.

1.
2.
3.
4.
5.

[024] Which of the subject areas covered in the curriculum do you think will be of greatest help to you in the practice area? **BCDE**

[025] What are the subject areas (if any) you would like to cover in greater depth? **BCDE**

[026] What are the subject areas (if any) you think you cover in too much depth? **BCDE**

[027] What if anything, do you understand by the term "holistic care" ? **BCDE**

[028] How important do you think holistic care is to nursing practice ? **BCDE**

Extremely important			Not at all important
4	3	2	1

Comments:

253

[029] How important do you think nursing research is to nursing practice? **BCDE**

Not at all important — Extremely important

1 2 3 4

If you have circled 3, or 4 please explain the role you think it has to play?

If you have circled 1 or 2 can you explain why you think it does not have a role to play?

[030] Have you had an opportunity to relate a research finding to your own practice? **BCDE**

YES ☐ If yes please give a practical example:

NO ☐ What makes this difficult?

Section Four - Your experience within the practice areas.

[031] Which of the following people have had the greatest influence upon you regarding your understanding of nursing to date? Please rank only those with whom you have had contact, and order your response with 1 being the greatest influence. **ABCDE**

☐ Tutors / Nursing Lecturers

☐ Health visitors, CPNs, District nurses

☐ Link Tutor

☐ Mentor

☐ Personal Tutor

☐ Other students /colleagues

☐ Ward sisters, Charge nurses (in general)

☐ Enrolled Nurses

☐ Staff Nurses

☐ Clients

☐ Auxiliaries/Health care Assistants

☐ Medical Staff

Others (please state)..

[032] Have you encountered anyone you consider to be a 'good nursing role model' ? **BC**

YES ☐ NO ☐

If YES please describe the qualities that make them a good nursing role model.

[033] In general, to what extent do you as a student, have to compromise your principles of nursing in order to 'fit in' and be 'accepted' by the nursing team members? **CDE**

Completely compromise			Do not compromise at all
4	3	2	1

Comments:

[034] To what extent have you found the ward / practice routine influences nurse's ability to meet client's individual needs? **BCDE**

Completely Influential			Not at all influential
1	2	3	4

Comments:

[035] To what extent (if any) do you think the trained staff see you as a nurse ? **BCDE**

See as a nurse			Do not see as a nurse
1	2	3	4

Comments:

[036] To what extent do you think qualified nurses within the practice area, assess you as a 'worker' or as a 'learner' ? **CDE**

Worker			Learner
1	2	3	4

Comments

[037] Please comment on the advantages and / or disadvantages of 'supernumerary status': **CDE**

Advantages: **Disadvantages:**

[038] What makes allocation to a practice environment a positive experience for you ? **BCDE**

[039] Please comment on the advantages and / or disadvantages of 'rostered service' ?. **E**

Advantages **Disadvantages**

Section Five:- Your understanding of nursing and its role within the changing system of health care.

Once again please answer these questions from your 'current' understandings as determined by your experience.

[041] Since beginning the Project 2000 course has your initial idea of what nursing is about (as answered in question 9), changed in any way ? **BCD**

YES ☐

(a) In what ways ?

(b) Please identify the cause of this change as specifically as you can:

NO ☐ could you please expand ?

OR: FOR Q'NAIRE E:

[O58] To what extent do you think your view of nursing has changed following your experience of 'rostered' service during this course? **E**

Not changed at all			Changed considerably
4	3	2	1

If you have circled 3, 2 or 1, in what ways has rostered service affected your views ?

If you have circled 4 please expand

[042] To what extent do you think nursing in general is changing ? **BCDE**

Changing considerably			Not changing at all
1	2	3	4

If you have circled 1 or 2 what do you think has been the major cause(s) of this change ?
If you have circled 3 or 4 please expand

[043] Do you think of yourself as a nurse ? **ABCDE**

YES ☐ What makes you think of yourself as a nurse ?

NO ☐ Why do you not think of yourself as a nurse ?

[044] As a Project 2000 nurse to what extent, if at all, do you see yourself as 'different' from traditionally trained nurses? **ABCDE**

Extremely different			Not at all different
4	3	2	1

If you circled 3 or 4 in what ways are you different?
If you circled 1 or 2 please outline your reasons for this:

[045] What five qualities do you think a "good" qualified nurse should possess? **ABCDE**

Please state your answer in order of importance, with 1 being the most important.

1.
2.
3.
4.
5.

[046] What do you understand by the term "basic nursing care". **BCDE**

047] To what extent is a nurse education necessary in order to give "good basic nursing care" ? **BCDE**

Necessary Unnecessary

1 2 3 4

Comments:

[048] What priority should a qualified nurse give to 'basic nursing care'? **BCDE**

High priority Low priority

1 2 3 4

Comments:

[049] What if anything, do you understand by the term "reflective practice" ? **BCDE**

[050] To what extent do you think you are able to reflect on your own practice ? **CDE**

Able to reflect Unable to reflect

1 2 3 4

What or who has influenced you in this ?

[051] If you can, please describe who makes up the multi-disciplinary team? **BCD**

[052] What contribution (if any) do you think nurses make towards multi disciplinary care provision ? **BCD**

Contribute a great deal Contribute very little

1 2 3 4

If you have circled 1 2 or 3 what is the contribution made ?
If you have circled 4 please expand

[053] How important do you think it is for nurses to have a role in influencing the policies that affect health ? ABCD

Extremely important — Not at all important

1 2 3 4

If you circled 1 or 2 please indicate how nurses could do this:
If you circled 3 or 4 please outline your reasons for this:

[056]
[057] What (if any) are the advantages / disadvantages of doing a Project 2000 course? BE

Advantages	Disadvantages

[054] To what extent do you think that your Project 2000 programme will appropriately prepare you to work as a qualified nurse ? CDE

Excellent preparation — Not at all prepared

4 3 2 1

Comments:

[057] To what extent do you think your view of nursing has changed following your experience of 'rostered' service during this course ? E

Not changed at all — Changed considerably

1 2 3 4

If you circled 3 or 4 please outline how your view of nursing has changed, AND identify the cause of this change as specifically as you can:

If you circled 1 or 2 please expand:

[055] **General comments / Anything you wish to add:** **ABCDE**

Thank you for your time and effort, it is much appreciated.

APPENDIX 9

Standard Student Letter

Student's Name
Address

Date

Dear Student (name)

We have been commissioned by the English National Board to study the recent changes in nurse education, and are seeking your co-operation as a Project 2000 student with this research. The study aims to explore the contribution that the course has on your development as a nurse, so that we are able to plan for the future and continue to improve education for nurses.

We would like to invite you to participate and would be grateful if you felt able to help with this study. We aim, with your permission, to give out questionnaires, designed specifically for this project, to your entire cohort whilst in college on some of your study days. We would like to give follow up questionnaires at approximately nine month intervals until you have completed the course, or until the beginning of 1995, whichever is sooner. This will enable us to get a good picture of the effects the course is having on your development as a nurse. At a later stage we would wish to interview a very small number of your cohort to enrich the questionnaire findings.

As nurses ourselves we appreciate that many demands are made on your time. However, your help in this important study would be very valuable. We envisage that each questionnaire will take approximately 1 hour of your time. The information that you give will be coded for anonymity and will be completely confidential, made available only to members of the research team for the purposes of the project. Participation is entirely voluntary and you are free to withdraw from the study at any time.

In anticipation may we thank you for your co-operation and we will be in contact with you in the near future. If you have any queries, or would like more information on the project, please feel free to ask us when you see us in college, or alternatively we may be contacted on the following telephone numbers (Tel no.).

Yours sincerely,

(Name)
Research Associate.

APPENDIX 10

Questionnaire Respondents and Attrition Rates

Table 50: Questionnaire Respondents and Attrition

Completed Questionnaires	Centre 1: Cohort 4	Centre 2: Cohort 8	Totals
A + B+ C	52	46	98
A+ B	13	12	25
A+ C	9	3	12
B + C	1	1	2
A	15	7	22
B	0	1	1
N (= People)	90(91)	70 (70)	161

Completed Questionnaires	Centre 1 : Cohort 3	Centre 2 : Cohort 7	Totals
B + C + D	19	35	54
B + C	14	8	22
B + D	4	2	6
C + D	3	7	10
B	18	11	29
C	0	6	6
D	5	0	5
N (= People)	63 (84)	69 (78)	162

Completed Questionnaire	Centre 1 Cohort 1 Jan	Centre 1 Cohort 2 May	Centre 2 Cohort 5 Jan	Centre 2 Cohort 6 May	Total
D + E + F	25	24	11	10	70
D + E	31	23	17	11	82
D + F	3	0	2	0	5
E + F	2	0	1	0	3
D	15	14	2	2	33
E	5	3	3	2	13
F	0	0	0	0	0
N (= people)	81 (90)	64 (93)	36 (37)	25 (25)	242

APPENDIX 11

Detailed Example of Breakdown of Categories from Tabulations

Category labels used in tabulations were the main concepts generated by participants. Other associated concepts were then bought together under these labels as illustrated below.

Q016 (Table 9) What do you understand by Nursing Care?

A) **Caring**
Helping/support
Approachable
Psychological care
Comfort

B) **Nursing the sick**
Care in hospital/comfort
Give treatment
Administer drugs
Technical skills

C) **Patient Orientated**
Individualised care
Total patient care
Partnership in care
Maintain dignity
Nurse-patient relationship
Patient advocate
Patient empowerment
Continuity of care
Empathy

D) **Quality Care**
Research based care
Nursing care
Professional manner
Care by qualified staff
High quality care

Q045 (Table 14) What are the qualities of a good qualified nurse?

A) **Caring**
Understanding
Firm but kind
Sensitivity
Psychological understanding
Helpful

B) **Nursing Knowledge**
Intelligence
Apply teaching to practise
Learning
Rationale behind action
Skilled in nursing process
Knowledge of illness
Planned care
Experience

C) **Professional Development**
Up to date
Willing to learn
Flexible/adaptable
Career minded
Preceptorship
Empathy/sympathy

D) **Professional Skills**
Reliable
Reflective
Initiative
Thorough/precise
Observant
Diplomacy/discretion
Experience
Nursing skills
Assessment
Teaching
Confidentiality
Competence
Accountability
Responsibility
Professionalism
Problem solving
Promote independence
Accuracy

APPENDIX 12

Statistical Tests

A) Independent Samples

i) Chi-squared Test

Test of whether two groups differ in respect to some characteristic.

Use when data frequencies are in discrete categories, and for two independent groups.

Observed and expected (expected in no association between variables existed) are compared.

Null hypothesis (no difference) tested by formula:

$$\boxed{\chi^2 = \sum_{i=1}^{r}\sum_{j=1}^{k}\frac{(O_{ij}-E_{ij})^2}{E_{ij}}}$$

where O = observed frequencies
E = expected frequencies

Quantity has degrees of freedom (df) of (r-1) (k-1)

where r = no. of rows
k = no. of columns

A 2 x 2 table has 1 df.

If the computed Chi-squared is greater than or equal to the tabulated value for a particular level of significance and for the specific df, REJECT the null hypothesis (i.e. accept that there is an association between the variables).

With 1 df, significant values of Chi-squared are:

probability	*value*
0.05	3.84
0.01	6.64
0.001	10.83

So if the arithmetic on the data produces a Chi-squared of 5.98, this is significant at the 95% level, but not at 99%.

Cells need to be 5 or above - an alternative test (Fisher) can be used when several cells are less than 5, or N is < 20.

ii) Mann-Whitney Test

Tests whether two groups are drawn from the same population.

Involves at least ordinal measurement.

Null hypothesis is that the two samples have the same distribution.

Alternative is that the first is greater than the second - and to accept this alternative hypothesis the probability of the difference between paired observations must be, generally in the sample, greater than 0.5 (i.e. Prob {a > b} is not equal to 0.5).

For a two-tailed test Prob {a > b} is not equal to 0.5.

Observations from both groups are combined and ranked in order of increasing size.

The value of U is simply the sum of the number of times that the score in the second group precedes a score in the first group.

For actual computation assign rank of 1 to the lowest score in the combined sample n(1) + n(2), and then:

$$\boxed{u = n_1 n_2 + \frac{n_1(n_1+1)}{2} - R}$$

where n(1), n(s) are the sizes of the sample groups
R(1) is the sum of the ranks assigned to group n(1).

The quantity below is normally distributed N(0,1):

$$\boxed{Z = \frac{u - \frac{n_1 n_2}{2}}{\sqrt{\frac{n_1 n_2 (n_1+n_2+1)}{12}}}}$$

(Note: lower part is standard deviation Ó(u) - see below)

Tied ranks are change variability, so the standard deviation is corrected for this:

$$\boxed{\theta_u = \sqrt{\left(\frac{n_1 n_2}{N(N-1)}\right)\left(\frac{N^3-N}{12} - \varepsilon T\right)}}$$

where N = n(1) + n(2)
T =
t is the number of observations tied for a given rank.

Test is analogous to t-test - but without the restrictive assumptions.

iii) Kolmogorov-Smirnov Test

Again, tests whether two independent samples come from the same population (or from a population with the same distribution).

This test is sensitive to differences in the structures of the distribution (i.e. measures of central tendency, dispersion, skewness etc.).

If the two samples come from the same distribution, then the cumulative percentage distributions will look similar.

The two cumulative functions are compared - and one subtracted from the other. The absolute greatest difference is then compared with the test statistic.

The test statistic is a function of sample size, i.e. Quantity =

$$\boxed{1.36 \times \sqrt{\frac{n_1 + n_2}{n_1 \times n_2}}}$$

where n (1) and n(2) are the two sample sizes.

Notes: 1.36 indicated 0.05 level of probability, and is replaced by 1.63 and 1.95 for 0.01 and 0.001 levels respectively.

If working in percentages rather than proportions you will use 136 not 1.36 etc.

These are two-tailed values.

B) Related Samples

i) Sign Test / McNemar Test

Measures significance of change, and is particularly used in 'before' 'after' designs.

Data are arranged in a two-way table:

	Second inquiry 1	2	3	4
First inquiry 1	same			
2		same		
3			same	
4				same

Conceptually it is possible to 'ignore' those whose responses are the same on both occasions. It is then possible to concentrate on those whose opinions change in 'upwards' or 'downwards' directions - the off-diagonal elements of the matrix.

i.e. Those who are unchanged for the lead diagonal of the before/after matrix. The other individuals are grouped above and below that diagonal. This test compares these two last components.

McNemar requires dichotomised data, while the Sign test can use a longer scale and therefore will make better use of some types of sample data.

'Aboves' minus 'belows' are compared and the quantity used is:

$$\boxed{\chi^2 = \frac{(|A - D| - 1)^2}{A + D}}$$

where A are the cells that change +/- in the matrix
D are the cells that change +/- in the matrix

There is 1 df.

Test criteria for Sign Test and McNemar Test are the same.

C) Kruskall-Wallis

One-way analysis of variance by ranks

Tests whether samples come from the same population or from populations with the same means.

Assume underlying continuity, and requires at least ordinal measurement of variable.

Samples are combined and ranked in a single series.

The sum of ranks for each sample is computed.

The test looks at the disparity between these totals.

If the null hypothesis is true and sample sizes are reasonable then the following quantity is distributed approximately as a Chi-squared with df k-1 (k = no. of samples).

$$H = \frac{12}{N(N+1)} \sum^{k} \frac{R_j^2}{n_j} - 3(N+1)$$

where k = number of samples
n(j) = number of cases in the jth sample
N = sum of all n(j), i.e. the number of cases in all samples combined
R(j) = sum of ranks in jth sample

D) Test of differences between proportions

Test statistic is:

{p(1) - p(2)} / SE {p(1) - p(2)}

where SE {p(1) - p(2)} = SQRT {P(1 - P) {(1 / n(1)) + (1 / n (2))}

and P = {n(1) * p(1) + n(2) * p(2)} / {n(1) + n(2)}

Quantity ('z') is approximately normally distributed.

Probability points are:

probability	*value* (values same as t test)
0.05 (95%)	1.96
0.01 (99%)	2.58
0.001 (99.9%)	3.29

Two tailed.

Result is significant if test statistic is greater than probability value (or less than if a negative value).

APPENDIX 13

Questionnaire F

I.D. CODE: ☐☐☐☐☐☐
(For Researchers Use)

Three Year Project Funded by the English National Board.

Project 2000 Study

Questionnaire for RN's (F)

All information is strictly confidential and will be coded for anonymity

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As you may remember the aim of this research is to begin to clarify the effect of the Project 2000 course on the "new nurse of the future", which is of course yourself.

The following questions ask for general information regarding your current position. This information is to provide the research team with background knowledge in order to gain a clear picture of your experiences since qualifying. We have made the following questions very general in order to encompass a wide range of potential experiences. If however your own personal experiences fall beyond the scope of the questions please elaborate as fully as you can.

[067] **1.** How long have you been working / did you work in your nursing related post ?

If less than 5 months, please state anything else you have been involved in since qualification:

[068] **2.** Please state the type of practice area in which you are working / have worked (E.g. Medical ward, community nurse, acute mental health area, home for people with learning disabilities, etc.)

[069] **3.** Please state the type / grade of post in which you have worked since qualification.

[070] **4.** How many hours per week are you contracted to work ?

[071] **5.** Please identify the skill mix of the team / unit in which you are currently working / have worked.

[072] **6.** Have you received any training/ education/ preceptorship since qualification?

The following questions attempt to firstly explore 'your' experiences of the Project 2000 course and secondly, your views and understanding of nursing now that you are qualified. Please answer ALL questions in as much detail as you can.

Some questions will ask you to make a choice, and will ask you to tick the box which corresponds best to your answer.

FOR EXAMPLE:

YES ☐ **NO** ☑

Other questions will ask you to RATE your response, by circling the number that best corresponds to your answer.

FOR EXAMPLE:

extremely easy			**not at all easy**
4	[✓ 3]	2	1

7. To what extent have you been able / wanting to continue your academic/ professional development since you qualified ?

[073] a)

Wanting to continue development			Not wanting to continue development
1	2	3	4

[074] b)

Able to continue development			Unable to continue development
1	2	3	4

[075] c) How have you developed since qualifying ?

[076] d) What factors have facilitated your academic/professional development?

[077] e) What factors have inhibited your development ?

[078] **8.** It has been suggested that Project 2000 nurses will initially find it more difficult to practice than traditionally trained nurses, because the course is based on theory rather than on practical skills. To what extent do you agree/ disagree with this view now you have qualified?

Strongly disagree — Strongly agree

4 3 2 1

Comments:

[079] **9.** From your recent experience in practice, do you think a 'gap' exists between the nursing theory you have explored and the practice of nursing you have experienced ?

[080] **10.** In what ways, if any, would you like to change nursing practice in the area in your most current post?

[081] **11.** To what extent do you think your Project 2000 course has equipped you with the skills necessary to enable you to effect changein the practice setting in general?

Has equipped me with the necessary skills — Has not equipped me with the necessary skills

4 3 2 1

If you have circled 3 or 4 please state what these skills are:

If you have circled 1 or 2 please expand

[082] **12.** To what extent do you feel you have been able to influence practice in the area in which you work ?

Able to influence practice — Unable to influence practice

1 2 3 4

If you have circled 1 or 2, please state why you feel able to do this ?

If you have circled 3 or 4, please state why you feel unable to do this ?

[083] **13.** From your experience, is there anything you would like to change about Nursing in general ?

[024] **14.** From your experience over the last three and a half years which of the subject areas covered in the Project 2000 curriculum have been the greatest help to you in the practice area ?

[025] **15.** Which of the subject areas would you have liked to have covered in greater depth ?

[026] **16.** Which of the subject areas do you feel you covered in too much depth?

[030] **17.** Have you had an opportunity to relate research finding(s) to your own practice?

YES ☐ If yes please give a practical example, and outline the benefits you feel have been gained from doing this ?:

NO ☐ What makes this difficult?

[049] **18.** What do you understand by the term "reflective practice" ?

[050] **19.** To what extent do you think you are able/unable to reflect on your own practice ?

Able to reflect			Unable to reflect
4	3	2	1

What or who has influenced you in this ?

[084] **20.** How valuable/not valuable is reflective practice to nursing ?

Extremely valuable			Not at all Valuable
1	2	3	4

If you have circled 1 or 2 please outline the reasons why you think it is valuable ?

If you have circled 3 or 4 please outline the reasons why you think it is not valuable ?

21. What are your priorities in practice, as a qualified nurse, AND what helps/prevents these priorities being met ?

[085] **Priorities**

[086] **What helps**

[087] **What prevents**

[088] **22.** As a qualified nurse in what ways, if at all, are you able to act as a health promoter ?

[019] **23.** In your opinion, how difficult or easy, is it to put health education / health promotion into practice in your practice environment?

Difficult			Easy
4	3	2	1

a) Please describe any difficulties you have encountered in putting health education/health promotion into practice:

b) Please describe what helps you to put health education/health promotion into practice:

[089] **24.** Which policies within your work area, do you think promote health ?

[090] **25.** Can you think of any policy to promote health you would like to see implemented?

[044] **26.** As a qualified Project 2000 nurse to what extent, if at all, do you see yourself as 'different' from non Project 2000 trained nurses?

Extremely different			Not at all different
4	3	2	1

If you circled 3 or 4 in what ways are you different?

If you circled 1 or 2 please outline your reasons for this:

[091] **27.** What do you think your non-Project 2000 nursing colleagues think of Project 2000 qualified nurses?

[033] **28.** In general, to what extent, if at all, do you as a qualified nurse, have to make compromises in your nursing practice in order to ' fit in' and be 'accepted' by the nursing team members?

Completely compromise			Do not compromise at all
4	3	2	1

If you have circled 2, 3 or 4 please give an example of any compromises you have had to make:

If you have circled 1 please say why this is?

[092] **29.** How is the work organized in your practice area?

[093] a) What influence does this have on your ability as a qualified nurse to meet clients individual needs?

[032] **30.** Have you encountered anyone you consider to be a good nursing role model ?

YES ☐ NO ☐

a) If YES please give the job title of this person/(s)?

b) Please describe the qualities that make a good nursing role model?

[094] **31.** To what extent do you think your views of nursing have changed since being in practice ?

Changed very little			Changed considerably
4	3	2	1

[095] a)In what ways, if any, have your views been affected ?

[017] **32.** What do you think is required for 'good' nursing care ?
Please state your answer in order of importance, with 1 being the most important:

1.

2.

3.

4.

5.

[096] **33.** What role(s), do you think a health care assistant or support worker should undertake in nursing practice ?

[048] **34.** What priority should be given to the delivery of 'basic nursing care' by qualified nurses?

High priority Low priority

1 2 3 4

Comments:

[097] **35.** What , if anything, does nursing contribute to the multi-disciplinary team, that no other group can ?

[098] **36.** Having now qualified as a registered nurse, and looking back over your nurse education, what would you see as the major strengths/weaknesses of the Project 2000 course, in preparing you for practice ?

Strengths Weaknesses

[099] **37.** Looking back over the last three and a half years, what / who has been the greatest influence upon your practice as a nurse ?

[100] a)Why have they held such importance for you ?

[054] **38.** Looking back over your nurse education to what extent do you think that your Project 2000 programme has appropriately prepared you to work as a qualified nurse ?

Excellent preparation			Not at all prepared
4	3	2	1

If you have circled 3 or 4 can you state which aspects of your course have been most influential ?
If you have circled 1 or 2 can you state what you feel the course lacked ?

39. Regarding your future career, where do you see yourself :

[101] a) In two years time?

[102] b) In five years time?

[103] **40.** Would you be willing to be interviewed by a member of the research team in the near future? The interview would be informal,arranged at your convenience, hopefully within your work environment, and the researcher will be the one you have already met in college.

☐ Yes I would be willing to be interviewed by a member of the research team

☐ No I would not be willing to be interviewed by a member of the research team

Please feel free to add any additional comments you may have regarding the research, Nursing, education or any issue you feel to be important from your experience. All the best in your future career.

[055] **General comments / Anything you wish to add:**

THE END!!! - WELL DONE!

Thank you for your time, and the effort involved in completing this questionnaire, it is much appreciated.

GOOD LUCK IN YOUR FUTURE CAREER!

APPENDIX 14

Interviewees Tables

Table 51: Centre One: Cohorts one and two. Interviewee Details

I.D. Code	Branch program. studied	Practice area	Length of time in post	Changed post since qualified	Previous post since qualified	Length of time in previous post
111608 cohort 1	Adult	G.I. surgery ward	9 months	YES	NURSE BANK	2 months
111623 Cohort 1	Adult	I. T. U	11 months	NO	-	-
111634 Cohort 1	Adult	opthalmic Day unit	11 months	NO	-	-
111641 Cohort 1	Adult	NHS Home for Elderly	8 months	NO	Un-employed	3 months
112665 Cohort 1	Mental Health	Adolescent Psychiatric unit	5 months	YES	Young Persons Unit	6 months
121622 Cohort 2	Adult	Medical ward	7 months	NO	-	-
121625 Cohort 2	Adult	Renal Dialysis unit	7 months	NO	-	-
121634 Cohort 2	Adult	Urology ward surgical	7 months	NO	-	-
122665 Cohort 2	Mental Health	Mental Health Rehab	7 months	NO	-	-
122667 Cohort 2	Mental Health	community mental health	7 months	NO	-	-

Table 52: Centre 2: Cohorts five and Six Interviewee Details

I.D. Code	Branch prog. studied	Practice area	Length of time in post	Changed post since qualified	Previous post since qualified	Length of time in previous post
251608 Cohort 5	Adult	Eye surgery ward	11 months	NO	-	-
251620 Cohort 5	Adult	Intensive care unit	5 months	YES	Trauma rotation	6 months
251621 Cohort 5	Adult	Coronary care unit	4 months*	YES	Medical ward	7 months
252623 Cohort 5	Mental Health	Acute Admiss. ward	11 months	NO	-	-
251630 Cohort 5	Adult	Elderly Rehab. ward	11 months	NO	-	-
261609 Cohort 6	Adult	Private ward	6 months	YES	Bank Nurse	1 month
261610 Cohort 6	Adult	Theatres	2 months*	YES	Medical ward	5 months
261617 Cohort 6	Adult	Surgical ward	6 weeks	YES	Medical ward	6 months
261618 Cohort 6	Adult	Surgical ward	6 weeks	YES	Care of the Elderly ward	6 months
261621 Cohort 6	Adult	Care of the Elderly ward	3 months	YES	Bank Nurse	4 months

APPENDIX 15

Qualified Diplomate Interview Guide

PROJECT 2000: PERCEPTIONS OF THE PHILOSOPHY AND PRACTICE OF NURSING

Is nursing perceived and practised differently - If so, is this anything to do with Project 2000 ?

1. Recap & clarify where working & for how long - organization set-up

2. Experience of being qualified nurse for last year / six months.

3. Differences between Student & staff nurse role
   ?Is what you felt as a student what you feel now

4. Reflections on Project 2000 course
   ? Adequate preparation

5. What does nursing mean to you?
   ? What is your philosophy
   ? What are your priorities/ hoping to achieve
   Has philosophy changed as a result of exposure to practice?

6. How do you feel the other staff see you (as having different qualities to offer or as one of them ?)

   ? Relationships with others
   ? Support systems

SUMMARY

? Difficult / stressful aspects
? Positive / enjoyable aspects

Where is nursing going ?

APPENDIX 16

Follow-up Letter to Interviewees

Interviewee's Name
Address

Date

Dear Interviewee (name)

Re: Project 2000: Perceptions Of The Philosophy And Practice Of Nursing

Further to our telephone conversation, many thanks for agreeing to take part in a one to one interview with me. As arranged we will meet at X on **Wednesday 11 January 1995 at 10.30 a.m.** to discuss your experiences of being a qualified nurse. I anticipate the visit lasting about one or one and half hours, and as previously you will remain unknown to everyone but myself, and will only be identified by an identification number. Your place of work and previous college of nursing will remain anonymous and will not be identified in any publications or reports.

Thanks for your time, I look forward to seeing you again, to catch up with your experiences since qualifying. If you have any problems with the above arrangements I would appreciate it if you would give me a call on (tel. no.) as soon as possible.

Best wishes
Your sincerely

(Name)
Research Nurse

APPENDIX 17

Nurse Teachers Focus Group Interview Invitation

Lecturer's Name
Address

Date

Dear (name)

As you may be aware, X and Y colleges of health care have been selected as a case study centre for the above research project. To date, I have been liaising with your colleague X, who I believe has mentioned my desire to hold a group discussion with lecturers such as yourself, in the near future.
I am therefore writing to you today to invite you to participate in this informal group interview, and to provide you with further information on which to base your decision. My colleague, Karen Jones and myself plan to be at the **Seminar room, X School of Community and Mental Health Care,** on **Wednesday 8 December 1993 at 2pm**. The group will focus upon:

1. How teachers consider the course may have changed students' and their own perceptions and understanding of nursing.
2. To explore the contribution that the Project 2000 course has made towards the students' process of socialisation into the professional role.

We hope this will stimulate a lively debate, and I would like to stress the informal nature of the afternoon. We anticipate the group lasting around 1 hour and 45 minutes, and certainly no longer than 2 hours. Refreshments will be provided.We realise that these are busy times and that you will have many demands. However this is an important study and your contribution would be greatly appreciated. Anything that you say will be treated in strict confidence will be coded for anonymity and will only be used for the purposes of the study. I enclose a project summary for your information, which explains the project as a whole, and which you may find useful.

I do hope you will be able to assist us with this study, and look forward to meeting you on 8 December. If you do not wish to take part, or are unable to attend, please contact me on (tel. no.) or at the above address.

Also, if you have any questions, or require clarification of any of the issues raised, please do not hesitate to contact me.

Best Wishes
Yours sincerely

(Name)
Research Associate

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APPENDIX 18

Practitioners' Follow-up Focus Group Letter

Practitioner's Name
Address

Date

Dear Practioner (name)

I am writing to you in my capacity as Research Associate, to invite you to participate in an ENB commissioned project, which is examining perceptions of the philosophy and practice of nursing in the light of the 'Project 2000' educational reforms. As part of this project we are planning to talk to F or G grade practitioners, like yourself, who have experience of working with 'Project 2000' students and qualified practitioners. Your views would be particularly welcome as we feel that your experience with these practitioners will aid our understandings in this important area.

I have been in contact with your colleague, X, who suggested you may be interested in taking part in this important study. We are planning to hold a focus group interview for practitioners like yourself in the X area on **Wednesday 30 November 1994.** It will be as informal as possible and will be a group of approximately ten practitioners, like yourself, who will be invited to contribute views on a range of issues pertinent to the 'Project 2000' students and diplomates. We hope to acheive representation across acute and community specialities including mental health and learning disabilities. The group will take the form of a discussion, and is anticipated to last no longer than two hours. We have planned the session for 2.00-4.00 p.m.on 30 November, however, at present we have no definite venue planned, but is likely to be in at X or Y. I will of course inform you as soon as possible should you agree to participate.

All your views and comments will be coded for anonymity, and neither yourself, nor the Trust for which you work will be identified in any publications or presentations emanating from the research. The data will only be used for the project purposes and you will be known only by members of the project team.

I enclose a summary of the project as a whole which I hope will be of interest. If you have any questions please do not hesitate to contact me on (tel. no.).

I do hope you will feel able to take part in this important study. I realise that it is short notice, and that your time is extremely valuable in these busy times, but hope you will consider finding time to share your views with us. Would you please return the attached slip in the SAE enclosed.

Best wishes
Yours sincerely

(Name)
Research Associate

APPENDIX 19

Managers' Follow-up Focus Group Letter

Manager's Name
Address

Date

Dear Manager (name)

RE: PROJECT 2000: PERCEPTIONS OF THE PHILOSOPHY AND PRACTICE OF NURSING

I am writing to you in my capacity as Research Associate on the above project, commissioned by the ENB which is examining perceptions of the philosophy and practice of nursing in the light of the 'Project 2000' educational reforms. To date I have been liasing with X, who has passed me your name. As part of this project we are planning to talk to managers of G grade practitioners, who have experience of 'Project 2000' students and qualified practitioners. Your views would be particularly welcome as we feel that your experience with these practitioners will aid our understanding in this important area.

We would like to invite you to participate in the study by attending a focus group interview for managers like yourself in the X area on October 20 1994. It will be as informal as possible and will be a group of approximately eight managers, like yourself, who will be invited to contribute views on a range of issues pertinent to the 'Project 2000' students and diplomates. It will take the form of a discussion, and is anticipated to last no longer than two hours.

We have arranged the session for the morning (10.00 - 12.00 approx.) at X and hope that you will be able to attend. All your views and comments will be coded for anonymity, and neither yourself, nor the Trust for which you work will be identified in any publications or presentations emanating from the research. The data will only be used for the project purposes and you will be known only to members of the project team.

I enclose a summary of the project as a whole which I hope will be of interest. If you have any questions please do not hesitate to contact me on (tel. no.).

I do hope you will feel able to take part in this important study. Would you please return the attached slip in the SAE enclosed. If you are able to participate I will send more details at the beginning of October 1994.

Best wishes
Yours sincerely

(Name)
Research Associate

APPENDIX 20

Demographic Characterisitics of Nurse Teachers

Table 53: Nurse Teachers' Demographic Characteristics

	CENTRE 1 (n=8)		CENTRE 2 (n=7)	
	n	%	n	%
GENDER				
Male	4	50%	4	57%
Female	4	50%	3	43%
AGE				
<30	0	0%	0	0%
31-40	3	38%	4	57%
41-50	3	38%	2	29%
51+	2	25%	1	14%
TIME IN NURSE EDUCATION				
1-5 years	3	38%	1	14%
6-10 years	3	38%	4	57%
11-20 years	2	25%	2	29%
21+ years	0	0%	0	0%
QUALIFICATIONS				
Teaching qualification	8	100%	7	100%
Degree	7	88%	7	100%
Post-graduate	3	38%	3	43%

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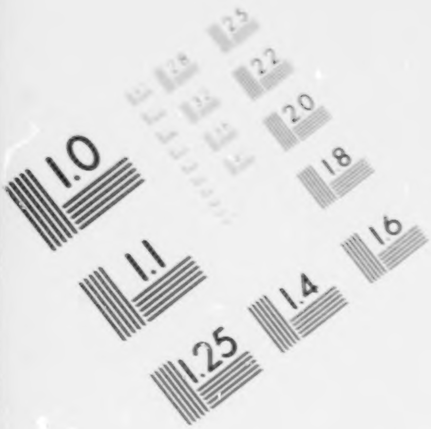
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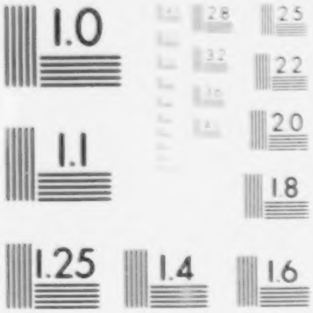
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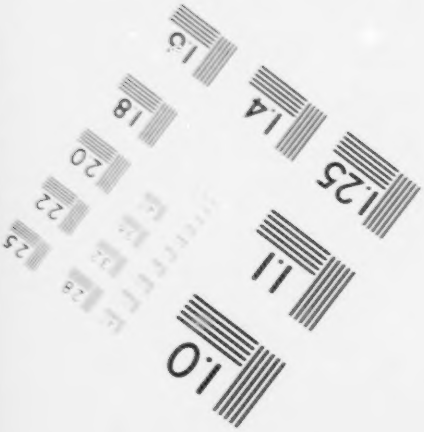
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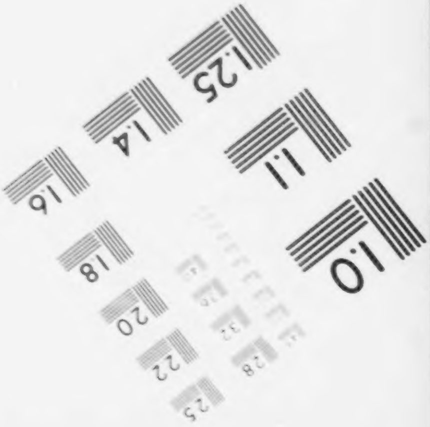
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APPENDIX 21

Demographic Characteristics of Practitioners

Table 54: Practitioners' Demographic Characteristics

	CENTRE 1 (n=9)		CENTRE 2 (n=12)	
	n	%	n	%
GENDER				
Male	1	11%	1	8%
Female	8	89%	11	92%
AGE				
<30	0	0%	0	0%
31-40	6	22%	9	75%
41-50	2	67%	2	17%
51+	1	11%	1	8%
TIME IN CURRENT GRADE				
1-5 years	6	67%	9	75%
6-10 years	2	22%	2	17%
11-20 years	1	11%	1	8%
WORKED WITH QUALIFIED P2K STAFF				
Yes	6	67%	9	75%
No	3	33%	3	25%

APPENDIX 22

Demographic Characteristics of Managers

Table 55: Managers' Demographic Characteristics

	CENTRE 1 (n=8)		CENTRE 2 (n=7)	
	n	%	n	%
GENDER				
Male	2	25%	3	43%
Female	6	75%	4	57%
AGE				
<30	0	0%	1	14%
31-40	3	38%	2	29%
41-50	4	50%	3	43%
51+	1	13%	1	14%
TIME IN MANAGEMENT				
1-5 years	3	38%	3	43%
6-10 years	3	38%	3	43%
11-20 years	2	25%	1	14%
21+ years	0	0%	0	0%
QUALIFICATIONS				
Degree/Post-graduate	4	50%	6	86%

APPENDIX 23

Topic Guides

a) Nurse Teachers

Areas to be explored

Brainstorm:

Can you think of any words which would describe the picture you have of a P2k student /traditionally trained nurse

Can you do the same for the picture you have of a qualified P2k practitioner / traditionally trained staff nurse.

1. Have your perceptions of nursing changed as a consequence of P2k ?

"Have your perceptions of nursing changed as a result of being involved with P2000?"

"If so, HOW and in what ways?"

"What has changed most?"

How do you feel about the educational changes taking place ?

2. Do you feel the students perceptions of nursing have changed because of P2k ?

What do they value as important ?

"What impact has the increase in theoretical teaching hours had on how P2000 students see nursing?"

AND "How they see practice?"

3. What contribution does the P2k course make toward the process of socialisation of the P2k student into the professional role

"Is the course adequately preparing students for their role in practice / once qualified?"

Where do students get to be socialised into their role as nurses ?

College or practice areas?

Is the balance right between time spent in the classroom and clinical teaching?

4. Has the nature of the NT's role in clinical practice changed since P2k ?

Whose responsibility is students learning in clinical practice?

Are there good role models in practice for students?

Are teachers seen as having Clinical credibility?

The integration of knowledge is important - where does it / can it happen?

Is the teaching of clinical skills of equal importance to theory behind practice?.

"Are st. becoming theorists with insufficient practical experience?"
"Is the balance right between hours spent in the classroom & in practice areas about right?"
"What are the main sources of knowledge /skill employed in practice?

b) Managers / Practitioners

The interview guides were essentially the same for both Managers and Practitioners and so have been amalgamated for inclusion in these Appendices. Any differences have been noted.

Focus Group Discussion Managers/Practitioners of G Grades

INTRODUCTION

Myself / Jill
Overview of project
Confidentiality / Anonymity
O.K to tape ?
One at a time

Brainstorm:

Can you think of any words which would describe the picture you have of a P2k student / traditionally trained nurse. (Managers only)

Can you do the same for the picture you have of a qualified P2k practitioner / traditionally trained staff nurse.

1. If you had to compare P2k students / qualified nurses with those who were pre P2k what areas if any would see as important comparisons

2. What is 'Nursing' to you ?

   What would you say it hopes to achieve ?
   What is important / what are nursing priorities ?
   What is your philosophy of 'nursing'

3. Is the RGN / Dip HE (P2k) producing the type of nurses you as senior nurses would want to employ ?

   What qualities do you as a manager want to see in a qualified nurse ? (what are the qualities a student should acquire during her nurse education ?)

   Have those qualities changed to meet the demands of nursing for the 1990's and beyond ?

   The UKCC stated that the nurse of the future would be a 'giver' as well as a 'supervisor' of care, what do you see the P2k qualifier being as a priority, a supervisor or giver of care? Explore the role of HCA.

4. 'Is the course adequately preparing St's for their role in practice / once qualified?' What difficulties do P2k qualified nurses encounter? (Practitioners only)

Who is responsible for the provision of clinical skills/educational input for students and newly qualified nurses? (Practitioners only)

What do you expect from the ward staff concerning educational input for students and newly qualified nurses ? (Managers only)

Who / what do you see as having the biggest impact in socializing the student into their role as nurses ? Has the P2k curriculum changed that in the past 5 years ?

How clinically competent should the newly qualified P2k nurse be in their first staff nurse role?

5. Is P2k having an impact on practice ?

Aims - Reflective practitioner
Research based practice
Flexible practitioner (non / institutional settings)
Thinking with analytical skills
Politically aware
Health promoting

END WITH : How do you see 'Nursing' developing in the next ten years ?

Is Project 2000 (RN Dip HE) preparing nurses for the 1990's and beyond ?
What are the major strengths / weaknesses of it ?

DO ALL COLLEAGUES SHARE YOUR VIEWS ON P2K?

APPENDIX 24

Breakdown Of Questions Asked At Respective Access Points On The Course

Question	A	B	C	D	E	F
Q001	√	√		√		
Q002	√	√		√		
Q003	√	√		√		
Q004	√	√		√		
Q005	√	√		√		
Q006	√	√		√		
Q007	√	√		√		
Q008	√	√		√		
Q009	√	√		√		
Q010	√	√	√	√		
Q011	√	√	√	√	√	sim to Q101 & Q102
Q012	√	√				sim to Q079
Q013			√	√	√	sim to Q079
Q014	√	√				sim to Q079
Q015			√	√	√	sim to Q079
Q016	√	√	√	√	√	
Q017	√	√	√	√	√	√
Q018	√	√	√	√	√	Q088, Q089, Q090
Q019			√	√	√	√
Q020		√	√	√	√	sim to Q078
Q021		√	√	√	√	
Q022	√	√	√	√	√	
Q023	√	√	√	√	√	
Q024		√	√	√	√	√
Q025		√	√	√	√	√
Q026		√	√	√	√	√
Q027		√	√	√	√	
Q028		√	√	√	√	
Q029		√	√	√	√	

Q030		√	√	√	√	√
Q031	√	√	√	√	√	sim to Q099
Q032		√	√			√
Q033			√	√	√	√
Q034		√	√	√	√	
Q035 Not analysed		(√)	(√)	(√)	(√)	
Q036 Not analysed			(√)	(√)	(√)	
Q037			√	√	√	
Q038		√	√	√	√	
Q039					√	
Q040 Not analysed						
Q041		√	√	√	sim to Q057	sim to Q095
Q042		√	√	√	√	
Q043	√	√	√	√	√	
Q044	√	√	√	√	√	√
Q045	√	√	√	√	√	
Q046 Not analysed		(√)	(√)	(√)	(√)	
Q047		√	√	√	√	sim to Q096
Q048		√	√	√	√	√
Q049		√	√	√	√	√
Q050			√	√	√	√
Q051		√	√	√		
Q052		√	√	√		sim to Q097
Q053	√	√	√	√		
Q054			√	√	√	√
Q055 Not analysed	(√)		(√)	(√)	(√)	(√)
Q056		√	√		√	sim to Q098
Q057					√	
Q067 -Q103						√

NB: There were no Questions 058 to 066.

APPENDIX 25

Chi-square & Mann Whitney Tables: Q054 Prepared for Practice

Table 56: Prepared for practice by cohort

	Centre 1			Centre 2			
Count Expected value row %	Cohort 1	Cohort 2	Cohort 3	Cohort 4	Cohort 5	Cohort 6	Row Total
Not prepared	14 16.8 23.0%	10 14.2 16.4%	5 7.0 8.2%	7 7.9 11.5%	9 5.4 14.8%	16 9.8 26.2%	61 23.3%
Prepared	58 55.2 28.9%	51 46.8 25.4%	25 23.0 12.4%	27 26.1 13.4%	14 17.6 7.0%	26 32.2 12.9%	201 76.7%
Column Total	72 27.5%	61 23.3%	30 11.5%	34 13.0%	23 8.8%	42 16.0%	262 100%

Chi-Square	Value	DF	Significance
Pearson	11.48133	5	.04263

Maximum expected frequency: 5.355
Number of missing observations: 5

Mann-Whitney

Mean Rank	Cases		
142.17	163	Centre 1	U = 6329.0
113.93	99	Centre 2	W = 11279.0
	262	Total	Z = -3.3899

2-tailed p = .0007 (corrected for ties)

NB: When examining the Mann-Whitney test results the small range of values (four point scale should be taken into account)

Table 57: Prepared for practice by age

Count Expected value row %	17-20	21-25	26-30	30+	Row Total
Not prepared	4 8.3 6.7%	33 27.6 55.0%	5 9.4 8.3%	18 14.6 30.0%	60 23.6%
Prepared	31 26.7 16.0%	84 89.4 43.3%	35 30.6 18.0%	44 47.4 22.7%	194 76.4%
Column Total	35 13.8%	117 46.1%	40 15.7%	62 24.4%	254 100%

Chi-Square	Value	DF	Significance
Pearson	7.99474	3	.04612

Maximum expected frequency: 8.268
Number of missing observations: 13

APPENDIX 26

Question 031 Second Responses

Table 58: People with greatest influence upon understanding of nursing (question 031): Second responses

Questionnaire:	A (Start)		B (9 months)		C (18 months)		D (27 months)		E (End)	
Category	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
Clients	3	2.5%	18	9%	14	8%	13	5%	14	10%
Enrolled nurses	3	2.5%	4	2%	10	5%	13	5%	8	6%
Friends/family	1	1%	0	0%	0	0%	0	0%	1	1%
Health care assistants	2	1.5%	6	3%	5	3%	3	1%	3	2%
Community staff	2	1.5%	39	19%	6	3%	11	4%	8	6%
Link teacher	0	0%	0	0%	1	1.5%	3	1%	1	1%
Medical staff	1	1%	2	1%	0	0%	2	1%	1	1%
Mentor	0	0%	23	11%	36	19%	60	23%	30	22%
Nurse manager	0	0%	0	0%	0	0%	0	0%	0	0%
Other students	46	32%	22	10%	10	5%	17	7%	2	1%
Personal teacher	51	35%	14	7%	10	5%	18	7%	5	4%
Staff nurses	7	6%	31	15%	47	25%	64	25%	39	28%
Teachers/lecturers	18	14%	43	20%	33	18%	42	16%	10	7%
Ward sister	4	3%	7	3%	11	6%	14	5%	14	10%
Previous experience	0	0%	0	0%	1	1.5%	0	0%	1	1%
Myself	0	0%	0	0%	0	0%	0	0%	0	0%
School nurse	0	0%	0	0%	0	0%	0	0%	0	0%
Total respondents	144	100%	210	100%	186	100%	261	100%	137	100%

APPENDIX 27

Chi-square & Mann-Whitney Tables: Worker/Learner (Q036)

Table 59: Worker/learner by qualifications

Count Expected value row %	Higher Education	'A' Levels	GCSEs	No quals/ Access	Row Total
Worker	46 43.0 32.2%	17 24.7 11.9%	64 62.4 44.8%	16 12.9 11.2%	143 58.8%
Learner	27 30.0 27.0%	25 17.3 25.0%	42 43.6 42.0%	6 9.1 6.0%	100 41.2%
Column Total	73 30.0%	42 17.3%	106 43.6%	22 9.1%	243 100%

Chi-Square	Value	DF	Significance
Pearson	8.22913	3	.04151

Maximum expected frequency: 9.053
Number of missing observations: 24

Table 60: Worker/learner by cohort

	Centre 1			Centre 2			
Count Expected value row %	Cohort 1	Cohort 2	Cohort 3	Cohort 4	Cohort 5	Cohort 6	Row Total
Worker	39 41.1 26.4%	22 32.3 14.9%	22 18.2 14.9%	23 19.4 15.5%	15 13.5 10.1%	27 23.5 18.2%	148 58.7%
Learner	31 28.9 29.8%	33 22.7 31.7%	0 12.8 8.7%	10 13.6 9.6%	8 9.5 7.7%	13 16.5 12.5%	104 41.3%
Column Total	70 27.8%	55 21.8%	31 12.3%	33 13.1%	23 9.1%	40 15.9%	252 100%

Chi-Square	Value	DF	Significance
Pearson	13.44489	5	.01955

Maximum expected frequency: 9.492
Number of missing observations: 15

Table 61: Worker/learner by branch

Count Expected value row %	Adult	Mental Health	Row Total
Worker	127 117.9 88.2%	17 26.1 11.8%	144 59.3%
Learner	72 81.1% 72.7%	27 17.9 27.3%	99 40.7%
Column Total	199 81.9%	44 18.1%	243 100%

Chi-Square	Value	DF	Significance
Pearson	9.46499	1	.00209

Maximum expected frequency: 17.926
Number of missing observations: 24

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